Reporting Obligations

Name The name of each report that you produce/receive	Description & Purpose A brief description of the report and its purpose including the intended audience and how it is being used (management decision making, accreditation, etc)	Performance Indicators If there is performance indicators included in the report please specify what they are?	Frequency How often the report needs to be provided (monthly, annually, etc)	Data Source (source, manual/electronic, ability to modify) Identify the source used to contribute the required information, if the data is collected manually or electronically and if the method of data collection can be modified to provide multiple uses.	Age of Data How old is the data that is being used to produce the report?	Roll Up for Territorial Reporting (yes/no) Is the data collected in a format that allows it to be rolled up with other HSSA data for Territorial level reporting?	Issues Issues affecting the generation of the report. What makes it difficult to produce the report? Is the data readily available?
Medevac Report	Track medevacs – for senior management and cabinet. Information can be used to see the financial impacts of not having certain procedures or resources available in the NWT.	Dispatch times and whether the contractor meets the standard of 45 from initial call to wheels up.	Monthly	Data comes from the medical travel system as well as an excel spreadsheet	Can be used for several years	It"s in excel so maybe?	Data integrity and if an error is made in the system it will also appear as such.
Annual medical travel statistics	Used in the STHA annual report and for the Department of Health to show how many NWT residents are transported	Not really, just shows the number of trips year over year.	Yearly	Data comes from the medical travel system and is manipulated in excel so these reports can be generated	Data is constantly evolving and available as far back as the system began	It"s in excel so maybe?	Data integrity issues. Limited reporting software makes reports much longer and tedious to generate
Quarterly medical travel statistics	Used by the Department on a quarterly basis to determine where core funding is being allocated. Also accompanies the variance report		Quarterly	Data comes from the medical travel system and is manipulated in excel so these reports can be generated	Data is constantly evolving and is available from the system"s introduction	It"s in excel so maybe?	Data integrity issues. Limited reporting software makes reports much longer and tedious to generate
Annual reports for THSSI funding	Report tracks medical travel utilization over the year. The report is used by the Department to		Yearly	Data comes from the medical travel system and is manipulated in excel so these reports can be	Data is constantly evolving and is available from	It"s in excel so maybe?	Data integrity issues. Limited reporting software makes reports

Name The name of each report that you produce/receive	Description & Purpose A brief description of the report and its purpose including the intended audience and how it is being used (management decision making, accreditation, etc)	Performance Indicators If there is performance indicators included in the report please specify what they are?	Frequency How often the report needs to be provided (monthly, annually, etc)	Data Source (source, manual/electronic, ability to modify) Identify the source used to contribute the required information, if the data is collected manually or electronically and if the method of data collection can be modified to provide multiple uses.	Age of Data How old is the data that is being used to produce the report?	Roll Up for Territorial Reporting (yes/no) Is the data collected in a format that allows it to be rolled up with other HSSA data for Territorial level reporting?	Issues Issues affecting the generation of the report. What makes it difficult to produce the report? Is the data readily available?
	offset financial loses to the MT program.			generated	the system"s introduction		much longer and tedious to generate
FMBS Supplemental funding report	High level reports which need to explain why the MT program is in a deficit situation. This assists the program in obtaining supplemental funding. The reports contain explanations and show stats on why costs have increased or revenues have decreased.		Yearly as required	Data comes from the medical travel system and is manipulated in excel so these reports can be generated	Data is constantly evolving and is available from the system"s introduction	It"s in excel so maybe?	Data integrity issues. Limited reporting software makes reports much longer and tedious to generate
Ad hoc reports for various third parties			Ad Hoc	Data comes from the medical travel system and is manipulated in excel so these reports can be generated	Data is constantly evolving and is available from the system"s introduction	It"s in excel so maybe?	Data integrity issues. Limited reporting software makes reports much longer and tedious to generate
Reports for funding entities such as Health Canada (NIHB)	These reports track medical travel statistics and financial costs for this clientele. These reports are required per the contribution agreement between		Yearly	Data comes from the medical travel system and is manipulated in excel so these reports can be generated	Data is constantly evolving and is available from the system"s introduction	It"s in excel so maybe?	Data integrity issues. Limited reporting software makes reports much longer and tedious to generate

Name The name of each report that you produce/receive	Description & Purpose A brief description of the report and its purpose including the intended audience and how it is being used (management decision making, accreditation, etc)	Performance Indicators If there is performance indicators included in the report please specify what they are?	Frequency How often the report needs to be provided (monthly, annually, etc)	Data Source (source, manual/electronic, ability to modify) Identify the source used to contribute the required information, if the data is collected manually or electronically and if the method of data collection can be modified to provide multiple uses.	Age of Data How old is the data that is being used to produce the report?	Roll Up for Territorial Reporting (yes/no) Is the data collected in a format that allows it to be rolled up with other HSSA data for Territorial level reporting?	Issues Issues affecting the generation of the report. What makes it difficult to produce the report? Is the data readily available?
	Health Canada and the GNWT.						
Medical Daycare Unit- daily stats	All of the above	Specifically the numbers and trends	As required	Manual collection into a excel data sheet	Collected daily	no	As it is all manual, the quality of data may not be accurate if staff has not updated the data source.
Endoscopy	Wait list/ Follow up lists	Specifically the numbers and trends	quarterly	From Medi-patient	current	Currently working with the Territorial Endoscopy working group	There are several layers in the wait list so challenging to ensure that when the data is given that the information is correctly understood.
Endoscopy	No show/cancellation	Specifically the numbers and trends	As required	Manual collection into a excel data sheet	Collected daily	?	
Endoscopy	indicators	Currently working with the Territorial Endoscopy working group to determine what should be collected					As it will be a manual collection, it is difficult to determine exactly what should be collected and what will be done with the data.

Name The name of each report that you produce/receive	Description & Purpose A brief description of the report and its purpose including the intended audience and how it is being used (management decision making, accreditation, etc)	Performance Indicators If there is performance indicators included in the report please specify what they are?	Frequency How often the report needs to be provided (monthly, annually, etc)	Data Source (source, manual/electronic, ability to modify) Identify the source used to contribute the required information, if the data is collected manually or electronically and if the method of data collection can be modified to provide multiple uses.	Age of Data How old is the data that is being used to produce the report?	Roll Up for Territorial Reporting (yes/no) Is the data collected in a format that allows it to be rolled up with other HSSA data for Territorial level reporting?	Issues Issues affecting the generation of the report. What makes it difficult to produce the report? Is the data readily available?
Cardiac diagnostics	Wait list/ Follow up lists	Specifically the numbers and trends	quarterly	From Medi-patient	current		
Staff certifications	indicator	% of staff with the appropriate hospital certifications.	quarterly	Report from staff development	Up to 3 mo	?	Cumbersome data collection and manual calculations. Requires staff time.
Medication reconciliation completion	Indicator	% of med reqs completed appropriately	Weekly for quarterly report	Manual by patient chart review	< 2 weeks	?	Cumbersome data collection and manual calculations. Requires staff time!
Endoscopy chart audit	Indicator	% of chart completed appropriately	Weekly for quarterly report	Manual by patient chart review	< 2 weeks	?	Cumbersome data collection and manual calculations. Requires staff time!
Dialysis	Quality indicators						Not currently being done due to cumbersome data collection and manual

Name The name of each report that you produce/receive	Description & Purpose A brief description of the report and its purpose including the intended audience and how it is being used (management decision making, accreditation, etc)	Performance Indicators If there is performance indicators included in the report please specify what they are?	Frequency How often the report needs to be provided (monthly, annually, etc)	Data Source (source, manual/electronic, ability to modify) Identify the source used to contribute the required information, if the data is collected manually or electronically and if the method of data collection can be modified to provide multiple uses.	Age of Data How old is the data that is being used to produce the report?	Roll Up for Territorial Reporting (yes/no) Is the data collected in a format that allows it to be rolled up with other HSSA data for Territorial level reporting?	Issues Issues affecting the generation of the report. What makes it difficult to produce the report? Is the data readily available?
							calculations. Requires staff time!
ER Volumes	Historical numbers of visits to the ER – Required for Contribution Agreement		quarterly	Medipatient – electronically	< 4 weeks	?	
Clinic No-Sows	Historical data pertaining to patient appointments and # of no shows – required for contribution agreement		Quarterly	Manually, review of day sheets	< 4 weeks	?	Day sheets sometimes arrive late. Report is due the end of the month immediately following the end of the quarter. This means there could be data missing
Medical Travel	Historical Data pertaining to volume of med travel trips and number of escorts – required for contribution agreement reporting		Quarterly	Manually	<4 weeks	?	Because of limitations within the Medical Travel info system, some degree of estimation is required. Not all trips are entered (i.e. if Med Travel does not book the trip)

Name The name of each report that you produce/receive	Description & Purpose A brief description of the report and its purpose including the intended audience and how it is being used (management decision making, accreditation, etc)	Performance Indicators If there is performance indicators included in the report please specify what they are?	Frequency How often the report needs to be provided (monthly, annually, etc)	Data Source (source, manual/electronic, ability to modify) Identify the source used to contribute the required information, if the data is collected manually or electronically and if the method of data collection can be modified to provide multiple uses.	Age of Data How old is the data that is being used to produce the report?	Roll Up for Territorial Reporting (yes/no) Is the data collected in a format that allows it to be rolled up with other HSSA data for Territorial level reporting?	Issues Issues affecting the generation of the report. What makes it difficult to produce the report? Is the data readily available?
OR No Shows	Historical number of scheduled surgeries and the number of times and reasons patients do not show		Quarterly	Manually	<4 weeks	?	Manual system, with no consistency in definitions. Requires manual counting
Workload units for Diagnostic Imaging	Used to determine complement staff, instrumentation and other resource needs – feeds into CIHI	Yes for Stanton	Quarterly for STHA and annually for CIHI	Electronic retrieval from Medipatient	12 months	CIHI data is processed by Finance	
Workload units for Laboratory	Used to determine complement staff, instrumentation and other resource needs – feeds into CIHI		Annually	Electronic from Laboratory Information System – for Stanton	12 months	CIHI data is processed by Finance	
Fecal Occult Blood Tests	Reported to Office of Chief Public Health Officer (OCPHO) – regulated reporting		Monthly	Electronic from Laboratory Information System – for NWT	1 month	To OCPHO	
Blood Product Utilization	National Reporting for Canadian Blood Services (CBS)– monitoring of transfusion practices for each NWT laboratory	Planned for this fiscal Reactivating the STHA Blood Utilization Committee	Monthly	Electronically form LIS	Monthly	CBS format - Excel	
Transfusion /Transmitted	National monitoring of blood product utilization		annually	Part electronic and Manual	12 months	To Public Health Agency of Canada	

Name The name of each report that you produce/receive	Description & Purpose A brief description of the report and its purpose including the intended audience and how it is being used (management decision making, accreditation, etc)	Performance Indicators If there is performance indicators included in the report please specify what they are?	Frequency How often the report needs to be provided (monthly, annually, etc)	Data Source (source, manual/electronic, ability to modify) Identify the source used to contribute the required information, if the data is collected manually or electronically and if the method of data collection can be modified to provide multiple uses.	Age of Data How old is the data that is being used to produce the report?	Roll Up for Territorial Reporting (yes/no) Is the data collected in a format that allows it to be rolled up with other HSSA data for Territorial level reporting?	Issues Issues affecting the generation of the report. What makes it difficult to produce the report? Is the data readily available?
Injuries Surveillance System (TTISS) Database						(PHAC)	
Canadian Partnership Against Cancer	National reporting of cancer screening for provinces and territories	Targeted age group screening Yield (outcomes) of screens	Annually	Information is collected in Picture Archiving System and manual data entry of reports This data is collected by the NWT Breast Screening Program	12 months	Data is collected in Excel format and the non-nominal data is also shared with OCPHO	
NWT Breast Screening Program	Data is collected, analyzed and reported by Breast Screening Coordinator	Turn-around-time between exam and report Turnaround time for investigation completion of abnormal exams % of targeted population screened and outcomes	Annually	Information is collected in Picture Archiving System and manual data entry of reports	12	Data is collected in Excel format and the non-nominal data is also shared with OCPHO	

Board Member and/or Community Member Questions

What questions are you being asked by your Board members and/or community members that you are unable to answer because you do not have the data or information. Please be specific
Samples of questions from MLAs in Legislative Assembly and Standing Committees that often require a large amount of manual research and quick turnaround time. Some expectations are unrealistic given the limits for the current systems Series 1 • Please provide the total number of emergency hospital visits for the fiscal year 2011-2012 and the current fiscal year. • Please provide the total number of visits to health centres for fiscal year 2011- 2012 and the current fiscal year. • Of the total number of emergency hospital and health centre visits during fiscal year 2011-2012 and the current fiscal year, how many were alcohol and/or drug related? • Of the total number of alcohol and/or drug related emergency hospital and health centre visits, how many were classified as mental health disorders with self-harming or suicidal indications? • Of the total number of alcohol and/or drug-related emergency hospital and health centre visits, how many individuals were released from care and how many were sent to institutions specifically for alcohol and/or drug treatment? Series 2 • Numbers of SLPs in your HSSA • SLP vacancies – how many and how long • SLP Caseload – how many peds on caseload, what portion of your caseload is peds, what portion is preschool • SLP waiting list – how many and how long is SLP wait list? Does your waitlist for children differ from general SLP waitlist? • Utilization of telehealth - challenges and successes with Telehealth • Any other issues around SLP services to support ECD – e.g. lack of preschool children being identified Series 3 1. (a) Under Section 6(a) and (b) of the NWT Mental Health Act, how many voluntary patients have there been throughout the Northwest Territories hospitals and health centres from the 2009-2010 fiscal year to the present? (b) Of those voluntary patients, how many were admitted into the hospital and how many were denied admittance during the same time period? (c)) Of those voluntary patients denied admittance, how many were reasoned due to lack of beds and/or space during the same time period? 2. (a) Under Section 8(1), what are the specific numbers in which a medical practitioner has had to make an order for detention for a psychiatric assessment from the 2009-2010 fiscal year to the present? (b) Under Section 8(3), how many reports has the Minister's office received since the 2009-2010 fiscal year to the present? 3. (a) Under Section 15(1),what are the specific numbers in which a medical practitioner had to apply to admit an involuntary patient from the 2009-2010 fiscal year to present? (b) Under Section 16(1) and (2), how many applications has the Minister examined, and how many applications were approved, and how many were refused during the same time period?

What questions are you being asked by your Board members and/or community members that you are unable to answer because you do not have the data or information. Please be specific
Series 4 • Exactly how are Medevacs organized for Colville Lake? Where do they originate from (which medevac base services Colville Lake)? • Is it possible to determine how many Medevacs are provided to Colville Lake each year? • Is there any data on response times for trips to Colville Lake? Expected response time? • Any other information that might assist the Minister in responding to Medevac related concerns in Colville Lake?
1. Any requests that involve information based on ICD coding for inpatient statistics is at least 3 months behind due to the fact that once documents for coding are received, it is sent out of the organization for coding. So in order to get statistics for 4th quarter of 2012/2013, we will need to wait until August or September 2013.
2.
3.
4.
5.
6.

Appendix C: Other Jurisdiction Insights

Alberta

Accountabilities: Alberta Health

The Alberta Department of Health has a combined focus in its planning, policy, and funding on health and wellness, including responsibility for certain programs for seniors. The department is also responsible for financial and reporting functions and internal controls with the intentions of:

- Offering reasonable assurance that transactions are properly authorized, executed in accordance with prescribed legislation and regulations, and properly recorded;
- Safeguarding the assets and properties of the Province under Ministry administration;
- Providing Executive Council, the President of Treasury Board and Minister of Finance and the Minister of Health information needed to fulfill their responsibilities; and
- Facilitating preparation of Ministry business plans and annual reports as required by the *Government Accountability Act*.

Further, the department sets the strategic policy, standards and regulations, as well as ensuring accountability and the fostering of innovations in health service delivery. The organizational structure of the Alberta Health system is provided in Figure 3.

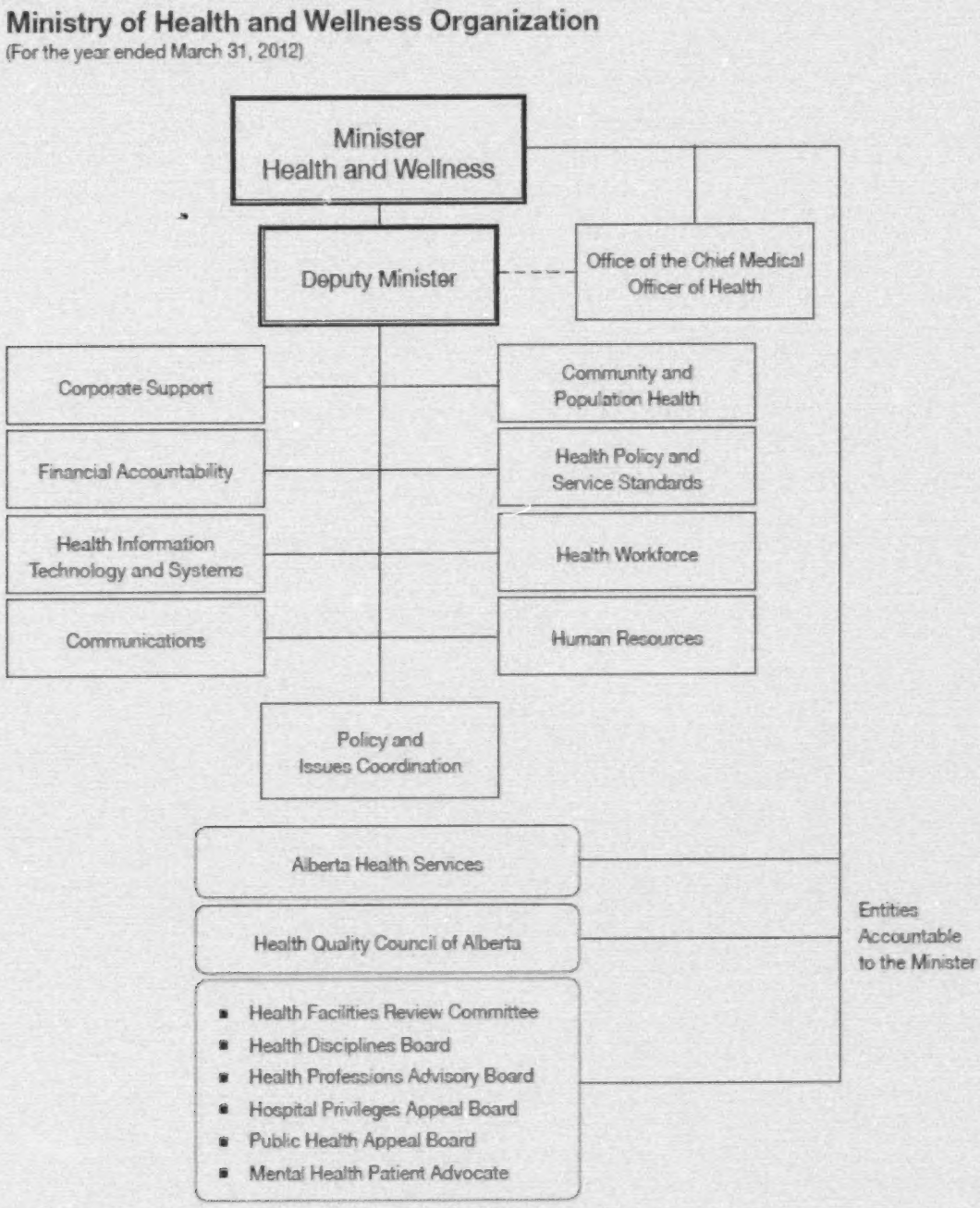
The Minister of Health is held ultimately responsible for the overall quality of health services in Alberta and is responsible for reporting to the Legislative Assembly. The Deputy Minister of the department supports the Minister and coordinates with the CEO of Alberta Health Services to provide direction, communicate government expectations and outline the strategic goals, guidelines and directions of the Provincial government. The Deputy Minister is accountable to the Minister and may exercise all of the powers, duties and functions of the Minister except making of regulations as defined in the Regulation Act.

A number of divisions exist within the Department of Health which are responsible for carrying out key activities for the health system and are accountable to the Deputy Minister.

Alberta Health has delegated the responsibility for the delivery of health services to one provincial authority: Alberta Health Services. Alberta Health Services is governed by a Board and is accountable to the Minister of Health for the delivery and operation of the public health system in Alberta[16]. The Government of Alberta has a five-year funding agreement with Alberta Health Services that expires at the end of fiscal 2014–2015. Alberta Health Services prepares and submits a health plan to the Minister which outlines the performance measures and targets for the organization in accordance with the Regional Health Authorities Act and the direction provided by the Minister of Health[17].

[16] http://www.albertahealthservices.ca/Publications/ahs-pub-2011-2015-health-plan.pdf.
[17] http://www.albertahealthservices.ca/3238.asp.

Figure 7: Organizational Structure of Alberta Health[18]



[18] Alberta Health and Wellness 2011-2012 Annual Report

Alberta Health Services is responsible for the following legislated mandate:

- Promote and protect the health of the population in Alberta and work toward the prevention of disease and injury;
- Assess on an ongoing basis the health needs of Alberta;
- Determine priorities in the provision of health services in Alberta and allocate resources accordingly;
- Ensure that reasonable access to quality health services is provided in and through Alberta; and
- Promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in Alberta.

Alberta Health Services has six wholly owned subsidiaries which assist with the delivery of health services in the province.

The Chief Medical Officer of Health (CMOH) is appointed by the Minister under the Public Health Act to monitor the activities of the government, Alberta Health Services, medical officers of health and executive offices on behalf of Albertans to protect and promote public health and prevent disease and injury. The CMOH is accountable to the Minister.

The Health Quality Council of Alberta is responsible to measure, monitor and assess patient safety and health service quality at the request of the Minister or the Alberta Health Services and is accountable to the Minister.

There are number of other entities that are also accountable to the Minister in the Alberta Health System as shown in Figure 3 above.

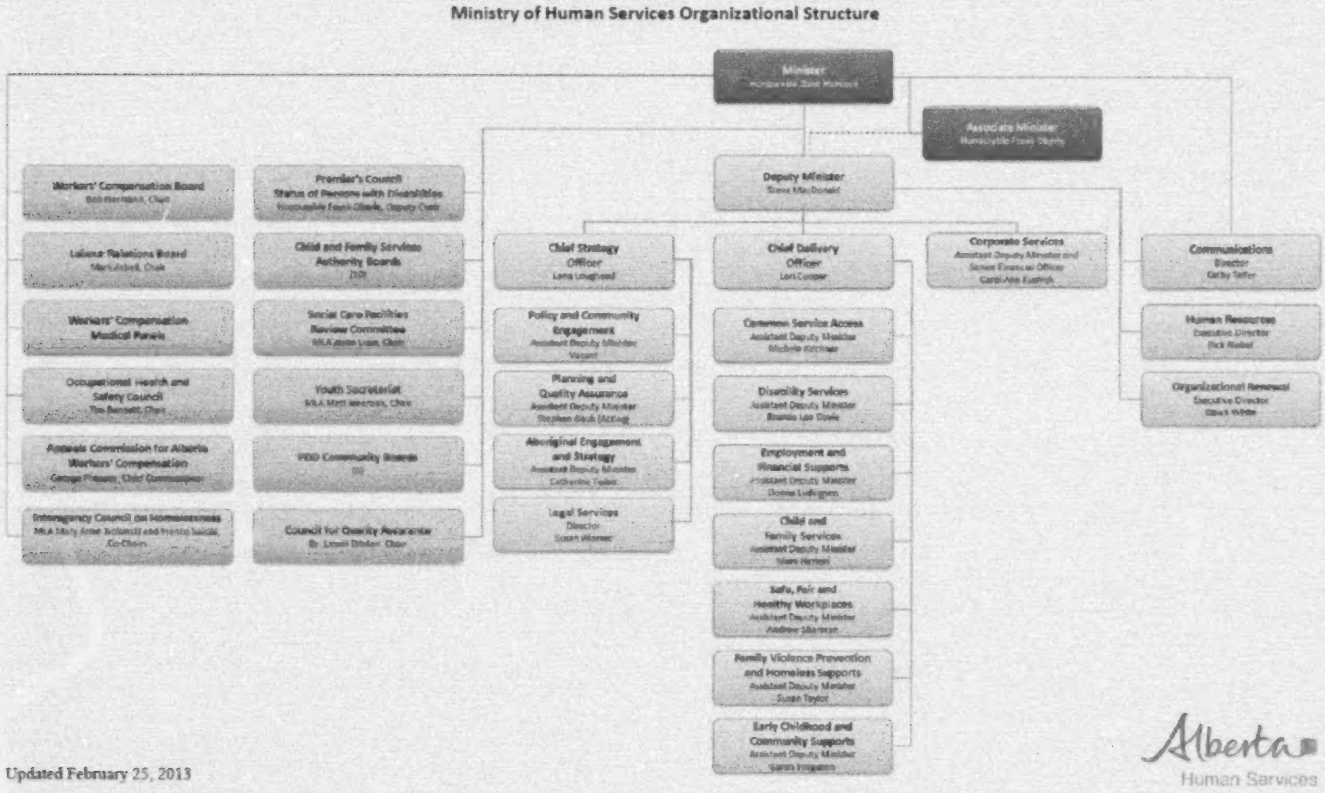
Accountabilities: Alberta Human Services

Alberta Human Services" mission is to assist Albertans in creating the conditions for safe and supportive homes, communities and workplaces so they have opportunities to realize potential. Its core business is to work collaboratively with community partners to deliver citizen-centered programs and services that improve quality of life for Albertans[19]. The recently merged Ministry of Human Services includes (Figure 4):

- The Department of Human Services
- Alberta Labour Relations Board
- Appeals Commission for Alberta Workers" Compensation
- Child and Family Services Authority Boards
- Occupational Health and Safety Council
- Secretariat for Action on Homelessness
- Social Care Facilities Review Committee
- Workers" Compensation Medical Panels
- Workers" Compensation Board
- Youth Secretariat

[19] http://humanservices.alberta.ca/department.html.

Figure 8: Organizational Structure for Alberta Human Services[20]



Despite this merger, the executives of the individual entities within the Ministry have retained their primary responsibility and are accountable to the Minister. Collectively, the executives ensure the Ministry complies with all relevant legislation, regulations and policies.

Reporting": Alberta Health

Alberta Health publishes an annual business plan and an annual report which contain 19 performance measures for the Alberta health system (Figure 5). The performance measures are organized into four categories including effective health system accountability, strengthened public health and healthy living, appropriate health workforce utilization, and excellence in health care.

[20] http://humanservices.alberta.ca/documents/organizational-chart.pdf.

Figure 9: Alberta Health Performance Measures[21]

Performance Measures Summary Table

Goals/Performance Measure(s)	Prior Years' Results				Target	Current Actual
Core Business : Leadership and governance						
1. Effective health system accountability						
1.a* Satisfaction with health care services received: Percentage of Albertans satisfied or very satisfied with health care services personally received in Alberta within the past year	58% 2005/2006	60% 2007/2008	61% 2009/2010	67% 2010/2011	65%	62% 2011/2012
2. Strengthened public health and healthy living						
2.a Smoking: Prevalence of smoking **						
• Alberta youth aged 12 to 19 years	11% 2005	10% 2007	12% 2008	12% 2009	9%	13% 2010
• Young adults aged 20 to 24 years	33% 2005	30% 2007	26% 2008	25% 2009	24%	30% 2010
2.b Influenza immunization: Percentage of Albertans who have received the recommended seasonal influenza immunization***						
• Seniors aged 65 years and over	60% 2007/2008	58% 2008/2009	56% 2009/2010	59% 2010/2011	75%	61% 2011/2012
• Children aged 6 to 23 months	64% 2007/2008	43% 2008/2009	16% 2009/2010	25% 2010/2011	75%	29% 2011/2012
• Residents of long term care facilities	94% 2007/2008	95% 2008/2009	91% 2009/2010	90% 2010/2011	95%	91% 2011/2012
2.c Sexually transmitted infections: Rate of newly reported infections (per 100,000 population)***						
• Chlamydia	329 2007	344.7 2008	379.3 2009	356.1 2010	330	371.2 2011
• Gonorrhea	64 2007	60.8 2008	43.8 2009	32.5 2010	50	39.6 2011
• Syphilis	7.3 2007	7.0 2008	7.7 2009	4.7 2010	6.5	2.4 2011
3. Appropriate health workforce utilization						
3.a Access to primary care through Primary Care Networks: Percentage of Albertans enrolled in a Primary Care Network**	—	—	55% 2008/2009	60% 2009/2010	68%	67% 2010/2011
4. Excellence in health care						
4.a* Patient safety: Percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year	13% 2005/2006	10% 2007/2008	9% 2008/2010	12% 2010/2011	9%	11% 2011/2012

[21] 2011-2012 Health and Wellness Annual Report

Goals/Performance Measure(s)		Prior Years' Results				Target	Current Actual
4.b	Continuing care:						
	Number of persons waiting in an acute care hospital bed for continuing care	645 2007/2008	754 2008/2009	707 2009/2010	471 2010/2011	375	467 2011/2012
	Number of persons waiting in the community for continuing care	–	1,065 2008/2009	1,039 2009/2010	1,110 2010/2011	900	1,002 2011/2012
4.c	Wait time for hip replacement surgery: 90th percentile wait time in weeks	36 2007/2008	36 2008/2009	35 2009/2010	39 2010/2011	27	40 2011/2012
4.d	Wait time for knee replacement surgery: 90th percentile wait time in weeks	49 2007/2008	48 2008/2009	49 2009/2010	49 2010/2011	35	48 2011/2012
4.e	Wait time for cataract surgery: 90th percentile wait time in weeks	28 2007/2008	30 2008/2009	42 2009/2010	47 2010/2011	30	35 2011/2012
4.f	Alberta Netcare: Number of care providers accessing Alberta Netcare**	29,110 2007/2008	34,200 2008/2009	39,866 2009/2010	– 2010/2011	45,229	– 2011/2012
4.g	Physician utilization of electronic medical records: Percentage of community physicians using the Electronic Medical Record in their clinic	45% 2007/2008	46% 2008/2009	46% 2009/2010	53% 2010/2011	60%	57% 2011/2012
4.h	Generic drug spending in Alberta: Community dispensed percentage of generic prescription drugs in Alberta	29.3% 2007	32.8% 2008	35.1% 2009	38.8% 2010	38%	41.9% 2011

*** Indicates Performance Measures that have been reviewed by the Office of the Auditor General**
The performance measures indicated with an asterisk were selected for review by ministry management based on the following criteria established by government:

- Enduring measures that best represent the goal and mandated initiatives.
- Measures for which new data is available.
- Measures that have well established methodology.

The performance measures for Alberta Health were developed based on the following criteria:

- **Reliability** – information used in applying performance measure methodologies agrees with underlying source data for the current and prior years" results.
- **Understandability** – the performance measure methodologies and results are presented clearly.
- **Comparability** – the methodologies for performance measure preparation are applied consistently for the current and prior years" results.
- **Completeness** – goals, performance measures and related targets match those included in the provincial budget.

In addition to the performance measures published by Alberta Health, Alberta Health Services publishes a quarterly report with 60 performance indicators. This includes 50 that are from the provincial action plan and approved by the Government of Alberta and 10 that are directly related to Alberta Health Services" priority areas. The dashboard from the December 13, 2012 performance report is provided in Appendix F. Alberta Health Services also updates its performance targets every three years within a five-year rolling cycle.

Next Steps for Alberta Health System Indicators

The Government of Alberta relies on a comprehensive set of indicators drawing from the tracking of health care delivery across the province, and focusing on a subset of those indicators at a strategic level. As observed by provincial government staff, the previous focus of indicators was on areas for attention and/or high risks. However, the reporting and progress with such a broad portfolio of metrics can be slow and/or not reflective of the overall achievements of the health sector.

The multitude of measures includes a number of input and/or output focused metrics, as proxies for the intended outcomes of health sector programs and services. The measures will stay in place for internal reference and operational management and there is a current interest in developing a smaller set (around 15) of balanced measures at a high level for provincial reporting. These measures are intended to represent health system outcomes, at the intervention level with a 1-5 year perspective, and include considerations of the social determinants of health. The reporting would be on a longer cycle (annual instead of quarterly); and, the focus will also be on appropriate time frames for the outcomes. For example, patient experience has a shorter term, while health status outcomes have a longer time to demonstrate results.

While the government and associated health services cannot be fully responsible for health outcomes, the future focus may be on building a strong community primary care foundation, health and wellness of the population and health system sustainability. In keeping with the strategic focus of these proposed measures, target setting will shift to the outcome level to encourage innovative problem solving.

Reporting: Alberta Human Services

Alberta Human Services are publishes an annual report and an annual business plan which contain 24 performance measures (Figure 6). The performance measures are categorized by goal. Additional performance measures related to specific populations and programs are reported at a greater level of detail, focusing on program delivery and impacts around:

- Abuse and Bullying
- Adoption
- Disability Services
- Family and Community supports
- Financial Supports
- Foster and Kinship Care
- Guardianship and Trusteeship
- Homelessness
- Newcomer Services
- Working in Alberta

Areas with specific plans and reporting include Homelessness, and Child and Family Services.

In addition to the reporting conducted by Alberta Human Services, the Government of Alberta publishes a report titled „Measuring Up" that reports on progress towards the goals of the government. Goal three in this report is "Strong Communities: Promote strong and vibrant communicates and reduce crime so Albertans feel safe". The performance measures for this goal include a number of aspects associated with social services at the highest level.

Figure 10: Alberta Human Services Performance Measures[22]

Performance Measures Summary Table

Goals/Performance Measures	Prior Years' Results				2011-12 Target	Current Actual
Goal 1: Vulnerable children, individuals and families are protected and supported in times of need.						
Percentage of children who suffer injury that results in hospitalization or death while receiving protective services	0.1% 2007-08	0.1% 2008-09	0.1% 2009-10	0.15% 2010-11	0%	0.14% 2011-12
Percentage of expenditures in the children/youth/families project and service category of Family and Community Support Services[1]	49.3% 2007-08	48.7% 2008-09	45.8% 2009-10	42.1% 2010-11	50%	46.0% 2011-12
Percentage of Albertans who have information to better help in situations of family violence or bullying:*						
• Family violence	66%[2]	N/A	73%	N/A	73%	71%
• Bullying	65% 2007-08	N/A 2008-09	65% 2009-10	N/A 2010-11	67%	74% 2011-12
Percentage of adults staying at government-funded women's emergency shelters who report that they are better able to keep themselves and the children under their care safer from abuse	96.1% 2007-08	96.7% 2008-09	96.8% 2009-10	96.8% 2010-11	95%	94.1% 2011-12
The number of children in the permanent care of the Director for whom Adoption or Private Guardianship Orders are granted	509 2007-08	550 2008-09	579 2009-10	551 2010-11	597	531 2011-12
Percentage of children and youth who received child intervention (family enhancement or protective services) and did not require protective services within 12 months of file closure	87% 2007-08	86% 2008-09	90% 2009-10	89% 2010-11	87%	88% 2011-12
Percentage of Aboriginal children in foster care/kinship care who are placed with Aboriginal families	38.5% 2007-08	38.7% 2008-09	39.9% 2009-10	40.7% 2010-11	50%	42.7% 2011-12
Percentage of participants employed after leaving Income Support	61% 2007-08	64% 2008-09	52% 2009-10	63% 2010-11	70%	64% 2011-12
Goal 2: Alberta has a fair, safe, healthy and inclusive workplace and a skilled labour force that contributes to economic prosperity.						
Percentage of clients reporting they are either employed or in further education or training after leaving a skills training program*	73% 2007-08	75% 2008-09	68% 2009-10	72% 2010-11	75%	77% 2011-12

[22] Alberta Human Services 2011-2012 Annual Report.

Goals/Performance Measures	Prior Years' Results				2011-12 Target	Current Actual
Inter-provincial rank of Alberta's labour force participation rate (#1 is the highest)	#1 74.2% 2007	#1 74.7% 2008	#1 74.3% 2009	#1 72.9% 2010	#1	#1 73.7% 2011
Inter-provincial rank of Alberta's First Nations, Métis and Inuit off-reserve labour force participation rate (#1 is the highest)	#1 72.3% 2007	#1 71.5% 2008	#3 69.9% 2009	#1 70.6% 2010	#1	#1 67.7% 2011
Lost-Time Claim Rate: number of lost-time claims per 100 person-years worked	1.98 2007	1.73 2008	1.53 2009	1.41 2010	1.55	1.49 2011
Number of new immigrants to Canada who choose Alberta as their destination	20,860[2] 2007	24,200 2008	27,017 2009	32,650[2] 2010	27,000	30,941[3] 2011
Percentage of employers whose employment practices resulted in no complaints being registered with Employment Standards	98% 2007-08	97% 2008-09	98% 2009-10	97% 2010-11	98%	97% 2011-12
Percentage of collective bargaining agreements settled without a work stoppage (strike or lockout)	98.5%[2] 2007-08	98.9%[2] 2008-09	98.0%[2] 2009-10	99.7%[2] 2010-11	98%	99.0% 2011-12
Percentage of applications, with Board involvement, settled before reaching a formal hearing	56% 2007-08	67% 2008-09	58% 2009-10	55% 2010-11	57%	73% 2011-12
Percentage of decisions rendered within 90 calendar days from the completion of the hearing(s)	96% 2007-08	88% 2008-09	62% 2009-10	81% 2010-11	85%	80% 2011-12
Average number of days from when an appeal is received to when it is finalized: • Standard Appeals • Complex Appeals	144 182 2007-08	172 212 2008-09	153 180 2009-10	154 176 2010-11	135 165	141 170 2011-12
Percentage of decisions not challenged or overturned	95.9% 2007-08	98.1% 2008-09	97.2% 2009-10	97.8% 2010-11	98%	99.2% 2011-12
Goal 3: In collaboration with communities and stakeholders, the conditions and opportunities are created for Albertans to succeed.						
Percentage of families accessing the Family Support for Children with Disabilities program that indicate the services provided had a positive impact on their child	N/A 2007-08	86.1% 2008-09	N/A 2009-10	89.5% 2010-11	N/A	N/A 2011-12
Percentage of youth receiving Advancing Futures Bursaries who successfully completed their planned studies during the fiscal year	N/A 2007-08	78% 2008-09	79% 2009-10	79% 2010-11	81%	83% 2011-12
Percentage of licensed day care centres and contracted family day home agencies that are accredited and participating in accreditation*	N/A 2007-08	N/A 2008-09	N/A 2009-10	96.3% 2010-11	94%	96.5% 2011-12

Figure 11: Performance Measures for Goal 3 in Measuring Up Report[23]

Goal 3 – Strong Communities – Promote strong and vibrant communities and reduce crime so Albertans feel safe.

Goal Three Performance Measures (audited)	Targets 2011-12	Previous Results	Current Results	Trend – 3 - 5 Years (unaudited)
Public Perception of Safety in the Neighbourhood (see note 9)				
Percentage of Albertans who feel reasonably safe to very safe walking alone in their area after dark.	82%	82% (2010-11)	82% (2011-12)	
Participation in the Arts (see note 10)				
Percentage of adult Albertans who participated in arts activities or events.	91.0%	89.5% (2010-11)	86.0% (2011-12)	
Affordable Housing Units (see note 11)				
Number of affordable housing units approved for development.	667	2,005r (2010-11)	1,212 (2011-12)	
Albertans' Satisfaction with their Local Governments (see note 12)				
Percentage somewhat satisfied to very satisfied.	80%	72% (2010-11)	77% (2011-12)	
Goal Three Performance Measures (unaudited)				
Support for Albertans with Developmental Disabilities (see note 13)				
Satisfaction of families/guardians of adults with developmental disabilities with Persons with Developmental Disabilities-funded services.	n/a*	85.3% (2010-11)	n/a*	
Social and Emotional Development (see note 14)				
Percentage of Alberta children demonstrating:				
Healthy social development	Maintain or improve Alberta's result relative to the national average	Alberta 84.5% Canada 82.6% (2008-09)	**	Alberta
Healthy emotional development		Alberta 83.2% Canada 83.8% (2008-09)	**	Alberta
Violent Crime Rate (see note 15)				
Rate of violent crime per 100,000 population.	1 per cent annual decrease	-2% 1,513 (2009)	-3% 1,476 (2010)	
Property Crime Rate (see note 16)				
Rate of property crime per 100,000 population.	3 per cent annual decrease	-7% 5,336 (2009)	-8% 4,908 (2010)	
Volunteerism (see note 17)				
Percentage of adult Albertans who volunteered in their community.	83.0%	72.3% (2010-11)	80.4% (2011-12)	
Support for Albertans with Low Incomes Who Need Temporary Help (see note 18)				
Percentage of participants employed after leaving income support.	70%	63% (2010-11)	64% 2011-12	

r – revised

* not applicable (biennial survey)

** The National Longitudinal Survey of Children and Youth was discontinued in 2010. The last results are for 2008-09.

Notes:

Calendar years are presented, for example, as 2011; fiscal years are presented, for example, as 2011-12.

The numbered note references in the tables refer to the Sources and Notes section on pages 57 to 63 which summarizes the methodologies and data sources for each of the performance measures.

For full methodology, refer to Supplementary Information Measuring Up – unaudited, online at www.alberta.ca.

[23] Measuring Up: Progress Report on the Government of Alberta Strategic Plan. 2011-2012 Annual Report.

Next Steps for Alberta Human Services Indicators

There is a current initiative to further combine the multiple processes and points of data collection into a single client tracking system, called Moibus, however, this will take significant amounts of time and resourcing to accomplish. Programs currently collect and report data through internal templates, sharepoint systems, as well as larger client management systems.

Additional work continues through the Social Policy Framework, which is not currently associated with particular indicators or measures but contributes to the qualitative discussion around social policy values and interests, and is intended to inform provincial social policy changes in moving forward.
The Government of Alberta will continue to seek improvements around the foundational indicators of social services, including:

- Child and family services – in Alberta more detailed information is tracked by the Child and Family Services Authority, especially those related to children in care
- Income supports and the related effectiveness and impacts, including the case loads, and comparisons to unemployment/reemployment rates
- Low income cut offs and analysis of poverty rates – this allows for contextual understanding of economic prosperity across all members of the community
- Homelessness and associated vulnerable populations and programs
- First Nations interaction with the system – understanding that First Nations communities have different needs and complexity, to better understand and provide effective programs and services, as well as move towards improving social outcomes in those communities.

Saskatchewan

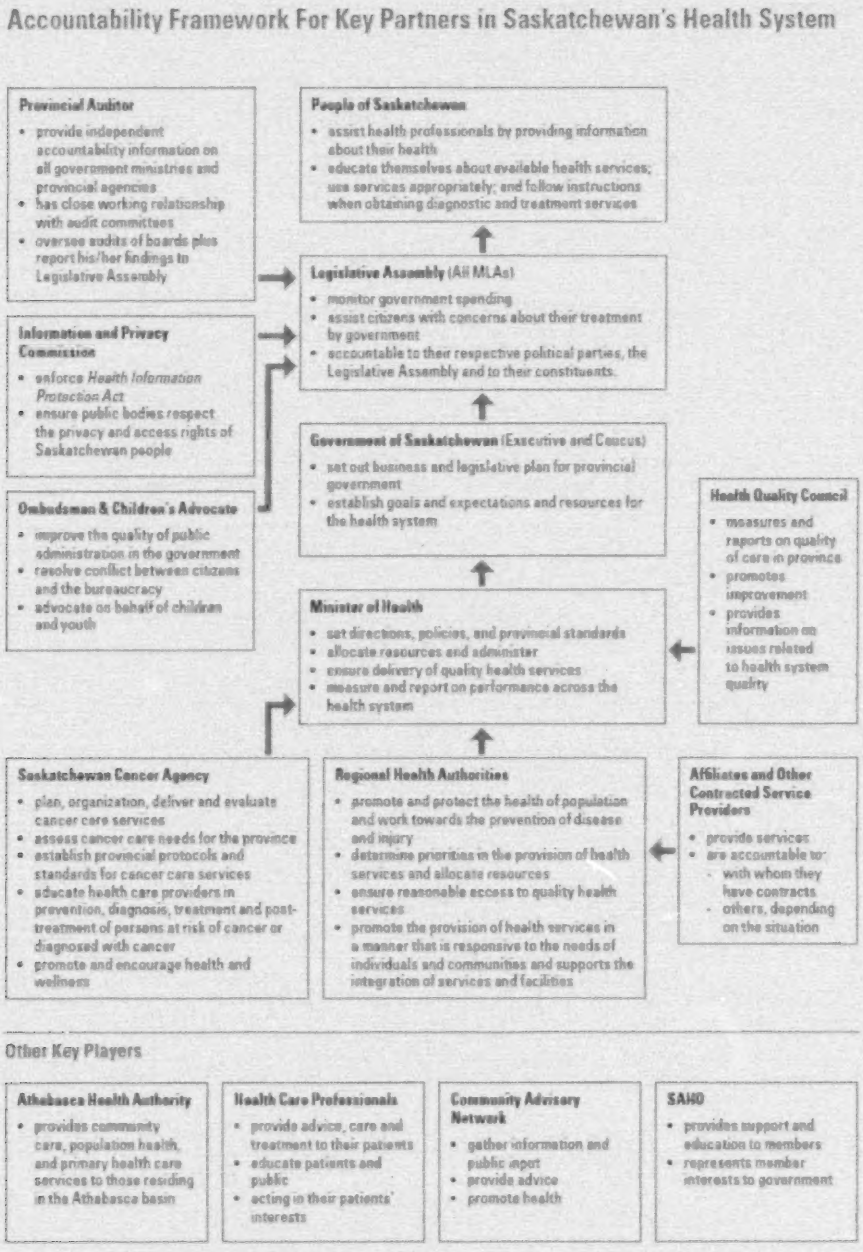
Accountabilities: Saskatchewan Ministry of Health

The most recent version of the Accountability Framework for the Saskatchewan Health system is published in the "Guide to Corporate Governance" developed by the Ministry of Health (Figure 8). Within the framework:

- Members of the Legislative Assembly are accountable to their electorate
- The Government of Saskatchewan, the Minister of Health, the Provincial Auditor and the Information and Privacy Commissioner and the Office of the Ombudsman & Children"s Advocate are accountable to the Legislative Assembly
- Regional health authorities, the Cancer Agency and health care organizations are accountable to the Minister of Health; and health care organizations and contracted service providers are accountable to the regional health authorities with which they have funding and service agreements.

Each year the Saskatchewan Ministry of Health issues a health-region-specific "Accountability Document", which sets out the Ministry"s expectations of regions for the funding that is provided. It contains both high-level organizational (governance and directional) expectations and program-specific expectations for the regions. These expectations are complementary to those articulated in legislation, regulation, policy, and directives. Information in the Accountability Document is intended to clarify the ways that the Ministry of Health will evaluate compliance with expectations.

Figure 12: Saskatchewan Health System Accountability Framework[24]


Accountability Framework For Key Partners in Saskatchewan's Health System
Provincial Auditor
• provide independent accountability information on all government ministries and provincial agencies
• has close working relationship with audit committees
• oversee audits of boards plus report his/her findings to Legislative Assembly
People of Saskatchewan
• assist health professionals by providing information about their health
• educate themselves about available health services; use services appropriately; and follow instructions when obtaining diagnostic and treatment services
Legislative Assembly (All MLAs)
• monitor government spending
• assist citizens with concerns about their treatment by government
• accountable to their respective political parties, the Legislative Assembly and to their constituents.
Information and Privacy Commission
• enforce Health Information Protection Act
• ensure public bodies respect the privacy and access rights of Saskatchewan people
Government of Saskatchewan (Executive and Caucus)
• set out business and legislative plan for provincial government
• establish goals and expectations and resources for the health system
Ombudsman & Children's Advocate
• improve the quality of public administration in the government
• resolve conflict between citizens and the bureaucracy
• advocate on behalf of children and youth
Health Quality Council
• measures and reports on quality of care in province
• promotes improvement
• provides information on issues related to health system quality
Minister of Health
• set directions, policies, and provincial standards
• allocate resources and administer
• ensure delivery of quality health services
• measure and report on performance across the health system
Saskatchewan Cancer Agency
• plan, organization, deliver and evaluate cancer care services
• assess cancer care needs for the province
• establish provincial protocols and standards for cancer care services
• educate health care providers in prevention, diagnosis, treatment and post-treatment of persons at risk of cancer or diagnosed with cancer
• promote and encourage health and wellness
Regional Health Authorities
• promote and protect the health of population and work towards the prevention of disease and injury
• determine priorities in the provision of health services and allocate resources
• ensure reasonable access to quality health services
• promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities
Affiliates and Other Contracted Service Providers
• provide services
• are accountable to:
- with whom they have contracts
- others, depending on the situation
Other Key Players
Athabasca Health Authority
• provides community care, population health, and primary health care services to those residing in the Athabasca basin
Health Care Professionals
• provide advice, care and treatment to their patients
• educate patients and public
• acting in their patients' interests
Community Advisory Network
• gather information and public input
• provide advice
• promote health
SAHO
• provides support and education to members
• represents member interests to government

[24] Guide to Corporate Governance. Saskatchewan Ministry of Health.

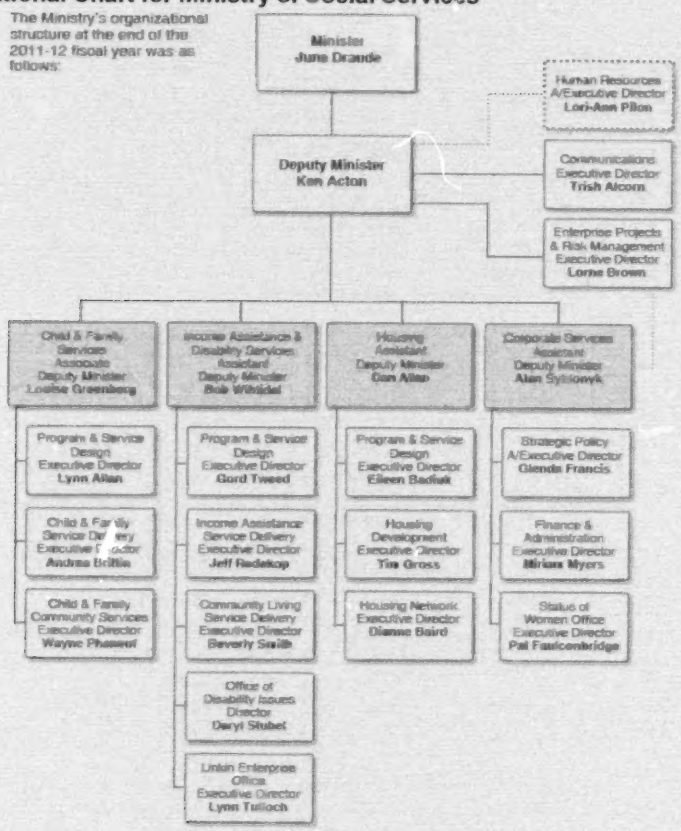
Changes to Health System Accountability

The Saskatchewan Health System has recently changed its approach to strategic planning, which will impact the Accountability Framework documented in Figure 6. However, the nature of these changes is unknown at this time. The new approach to strategic planning is based on Hoshin Kanri. Under this new approach, a provincial health leadership team has been established composed of representatives from Saskatchewan Health, health authority CEOs, Saskatchewan Cancer Agency and other partner organizations. The health leadership team will develop the strategic plan for the Saskatchewan Health system which includes health system performance metrics. Due to this new approach to planning, Saskatchewan Health is reviewing and considering eliminating the Accountability Document with the health authorities. The first Saskatchewan Health System Plan is expected for the 2013/2014 fiscal year.

Accountabilities: Saskatchewan Ministry of Social Services

The Saskatchewan Ministry of Social Services provides child welfare services, income support programs for low-income families, seniors and people with disabilities, social assistance programs for people out of work, housing programs and services to support families and people with disabilities. The Ministry delivers most of its programs through 20 service offices (as well as a number of day offices) in communities across the province. The organizational chart for the Ministry is provided in Figure 9.

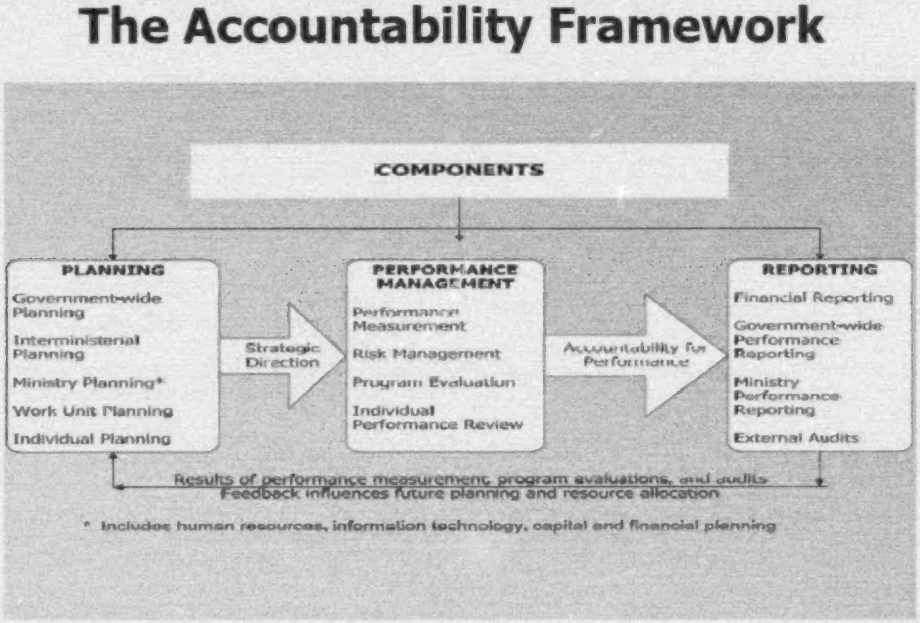
Figure 13: Organizational Chart for Ministry of Social Services[25]



[25] Based on the Ministry of Social Services 2011-2012 Annual Report.

The Government of Saskatchewan has developed an accountability framework that the Ministry of Social Services uses as a basis for developing their planning and performance measurement (Figure 10). There is also a growth plan for the Government of Saskatchewan that has growth targets for the province to the year 2020 that cascade down to the ministries.

Figure 14: Government of Saskatchewan Accountability Framework[26]



Reporting: Saskatchewan Ministry of Health

The Ministry of Health publishes performance measures in its annual reports and annual Ministry plans. The performance measures in the most recent 2011-2012 annual report are not exactly the same as the performance measures in the 2012-2013 Ministry plan. The performance measures in the newly developed 2013/2014 Saskatchewan Health System Plan may also be different, given the new approach to planning that was taken.

The following nine performance measures were published by the Ministry of Health in its 2011/2012 annual report. Included for each measure is a description of the significance of the measure and an analysis of the results. The data sources for each indicator vary depending on the indicator.

- Percentage of patients rating the hospital where they received their care as the "best possible hospital" (10 out of 10) (measures the patient experience and quality of care, tracked by the Health Quality Council)
- Surgery wait time indicators (quality of care indicators, Saskatchewan surgical registry)
    - Number of cases at March 31 that had already waited greater than 12 months for surgery
    - Number of cases at March 31 that had already waited greater than 18 months for surgery

[26] http://www.finance.gov.sk.ca/PlanningAndReporting/AccountabilityFrameworkDiagram.pdf

- Provincial hospital standardized mortality ratio (HSMR) for all Saskatchewan hospitals (quality of care). HSMR is calculated as the ratio of actual (observed) deaths to expected deaths, multiplied by 100 (based on CIHI calculation)
- Attendance Support Indicators. These are tracked and reported because studies suggest that healthy workplace environments in health care tend to contribute to higher quality services and positive work experiences for providers
    - Number of Sick Time Hours per Paid FTE in RHAs/SCA
    - Number of Loss Time Workers Compensation Claims per 100 FTEs* in RHAs/SCA
    - Number of Wage-driven Premium Hours per Paid FTE in RHAs/SCA
- University of Saskatchewan medical graduates establishing practices in Saskatchewan. The retention rate is defined as graduates who, six months after graduation, have been registered by the College of Physicians and Surgeons of Saskatchewan and are practicing in the province
- Financial performance against budget including an explanation for variances

The following seven performance measures were included in the 2012/2013 plan for the Ministry of Health. For each measure, a description is provided along with historical results.

- Better Health
    - Age Standardized Hospitalization Rate for Ambulatory Care Sensitive Conditions (rate per 100,000 population)
    - Tuberculosis (TB) Incidence Rate (rate per 100,000 population)
    - Rate of newly reported HIV cases (rate per 100,000 population)
- Better Care
    - Number of Patients Waiting for Surgery Longer than 6 months and 12 months
    - % Patients rating their hospital experience as 10 out of 10
- Better Value
    - % Health Care Budget Growth
- Financial Summary with projected budget for the upcoming year

In addition to the broad provincial system performance measures noted above, the Ministry of Health also has available on its website annual reports with statistics and specific indicators for the following:

- Medical Services Branch
- Drug Plan and Extended Benefits Branch
- HIV-AIDS Report (Public Health Branch)
- eHealth Saskatchewan

Other Health System Reporting

Reporting on the performance of the Saskatchewan Health system is also available on the „Quality Insight Online" website (http://www.qualityinsight.ca/indicators). This website contains over 100 indicators on health system performance and provides the ability to drill down into more detail. This website was developed and is maintained by Saskatchewan"s Health Quality Council.

Each Health Authority and the Saskatchewan Cancer Agency publish an annual report with performance measures specific for their region.

Data Collection

Currently, data collection within the Saskatchewan Health system involves a number of different databases and systems operated by different partner organizations. A lot of the data that inform the health system performance measures are supplied by the health regions and are consolidated and rolled up by the Ministry of Health. The Ministry also has some databases of collected data. The Saskatchewan Health system is working on a system-wide medical record that will help standardize data collection.

The Saskatchewan Health Quality Council has their own databases and also has contacts in the regions that collect data for them. The organization also administers the patient experience surveys in the province. The Health Quality Council is responsible for managing and collating the data it reports on.

eHealth Saskatchewan is developing a new data warehouse that will be accessible to the Ministry of Health and the Health Quality Council. All three parties are involved in the development of the warehouse.

A lot of the data for quality improvement at specific sites comes from the lean management initiatives. A lot of this is real-time data that can inform where and when improvements are required.

Next Steps for Performance Measurement

The performance measures and targets in the new health system plan are expected to change. The new health system plan may also eliminate the need to have Accountability Documents with the health authorities.

Reporting: Ministry of Social Services

The Ministry of Social Services publishes performance measures in its annual reports and annual Ministry plans. The performance measures included in the 2012/2013 Ministry Plan are aligned with the performance measures included in the 2011/2012 annual report.

The following ten performance measures were published in the Ministry of Social Services 2011/2012 annual report. For each measure, a description of the background of the measure as well as an analysis of the results is provided.

- Housing supply indicators
    - Housing market starts in Saskatchewan urban communities (i.e. population of 10,000 or greater)
    - Saskatchewan Housing Corporation completed units
- Number of families receiving the Saskatchewan Employment Supplement (monthly average)
- Proportion of children in out-of-home care who are placed with extended family members or other persons who have sufficient interest in the child (PSIs). Being placed with extended family, or other caregivers with whom they have an existing and significant relationship, is less emotionally difficult for a child than placement with a foster family whom the child may not know
- Number of families receiving child protection services from the Ministry
- Number of children living in foster homes with more than four placements
- Number of Saskatchewan Assured Income for Disabilities (SAID) beneficiaries (monthly average)

- Number of people with intellectual disabilities living in their own residences through Ministry-funded supported independent living programs
- Percentage of the Saskatchewan population 0-64 years of age who receive social assistance
- Ministry of Social Services Annual WCB Claims

The following six performance measures were included in the 2012/2013 plan for the Ministry of Social Services. For each measure, a description is provided along with historical results.

- Percentage of the Saskatchewan population 0-64 years of age who receive social assistance
- Number of children in out-of-home care
- Proportion of children in out-of-home care who are non-wards
- Housing market starts in Saskatchewan urban communities (i.e. population of 10,000 or greater)
- Saskatchewan Housing Corporation completed units
- Financial Summary with projected budget for the upcoming year

In addition to the provincial system measures noted above, the Saskatchewan Housing Corporation also publishes an annual report which is available on the Ministry of Social Services website. The report provides a discussion on performance measures specific to the Saskatchewan Housing Corporation as well as financial performance.

To inform performance measurement, the Ministry requires quality data in a timely fashion. Currently, most of the data is housed by the divisions in the Ministry which has created some challenges in getting data in a timely fashion[27].

Next Steps for Performance Measurement[28]

The Ministry of Social Services is currently working on improving and strengthening performance measurement by developing a balanced scorecard and focusing more on system outcomes. The Ministry is currently working on this at the strategic level and will cascade down to the divisions over time. The Ministry has worked on identifying its strategic directions and will link performance measures and targets to the strategic plan. There will be a focus on key measures that need to be influenced in the system. The Ministry will report on a small number of performance measures to the public at the strategic level and a larger number of measures internally for operational purposes.

As part of its strategic planning, the Ministry of Social Services has included a risk-management component. The Ministry has identified the key risks to achieving its strategic plan, assessed and prioritized them and assigned risk owners to those which need to be monitored and managed.

The Ministry is working on improving data collection and management through the development of a data warehouse. The data warehouse will allow the Ministry to pull together and manage data from different sources and should improve the quality and timeliness of data for reporting performance using the balanced scorecard.

[27] Based on discussions with representatives from the Ministry of Social Services
[28] Based on discussions with representatives from the Ministry of Social Services

Nova Scotia

Accountabilities: Department of Health and Wellness[29]

The Department of Health and Wellness is responsible for setting strategic direction and provincial policy to ensure services are accessible and timely: developing standards; monitoring, measuring and evaluating quality; conducting financial and human resources planning; administering the allocation of resources; and establishing requirements for information systems. The Department is also responsible for mental health and addiction services, physician services, pharmaceutical programs, primary health care services, emergency health services, continuing care services, public health, physical activity, sport, and recreation.

The Department provides funding to the District Health Authorities (DHAs) and the Izaak Walton Killam (IWK) Health Centre which are responsible for service delivery and resource management of the health and wellness system.

MNP was unable to find a documented accountability framework or organizational structure for the Department of Health and Wellness.

Accountabilities: Department of Community Services[30]

The primary responsibility of the Department of Community Services is to ensure the basic needs of individuals and families are met by providing financial support to persons in need and by protecting children and adults at risk. The department provides funding directly to clients and to service providers who provide prevention, residential, vocational, child care, housing, protection and other social services on behalf of the department.

The department has three core business areas including Housing, Employment Support and Income Assistance, and Family and Community Supports. MNP was unable to find a documented accountability framework or organizational structure for the Department of Community Services.

Reporting: Department of Health and Wellness

The Department publishes performance measures in an Annual Accountability Report and an Annual Statement of Mandate. All of the performance measures in the 2011/2012 Accountability Report and Statement of Mandate were the same. However, there were some differences in the performance measures included in the 2011/2012 Accountability Report and the 2012/2013 Statement of Mandate.

There were a total of 37 performance measures included in the 2011/2012 Accountability Report. For each performance indicator, a description is provided for what the indicator measures, what the current value of the measure is, and future targets. The data contained in the report comes from various sources that have different reporting time periods[31]. The performance measures include:

- Percent of Patients with Total Length of Stay from Triage to Emergency Department Departure within Emergency Care Standards indicators
    - Percent of Canadian Emergency Department Triage and Acuity Scale (CTAS) 1- 3 Patients with Total Length of Stay from Triage to Emergency Department Departure Being Within 8 Hours

[29] Nova Scotia Department of Health and Wellness 2012-2013 Statement of Mandate.
[30] Nova Scotia Department of Community Services 2012-2013 Statement of Mandate.
[31] Nova Scotia Department of Health and Wellness 2011-2012 Accountability Report.

  - Percent of CTAS 4 – 5 Patients with Total Length of Stay from Triage to Emergency Department Departure Being Within 4 Hours
- Percent of CTAS 4 – 5 Patients Being Seen in Emergency Departments
- Percent of Time that Paramedics Can Pass Responsibility of Care to Hospital Staff Within 20 Minutes of Arrival to the Emergency Department
- Percent of Patients Receiving Hip and Knee Replacement within National Benchmark. The national benchmark for each of these procedures was set to 26 weeks (or 6 months)
- Percent of Patients Beginning Radiation Therapy (RT) Within 8 Weeks and 4 Weeks
- Number of Facilities with Operating Rooms that Implement a Safe Surgical Checklist
- Health Care Services Offered in French and Number of Health and Wellness Documents Published in French
- Number of Clients Receiving Home Care Services
- Percent of Individuals Waiting for Long Term Care who are Receiving Home Care
- Number of Health Care Providers Using Electronic Medical Record (EMR)
- Retention Rate of New Nurse Graduates
- Percent of Adult and Child/Adolescent Mental Health Clients Seen Within the Provincial Wait Time Standard
- Number of Recommendations in the Auditor General"s Special Report on Pandemic Preparedness to which the Department of Health and Wellness has Responded
- Number of Recommendations from the H1N1 Lessons Learned Report To Which the Department of Health and Wellness has Responded
- Electronic Health Record (EHR) Initiative – Number of Clinical Users of SHARE (Secure Health Access Record)
- Number of Serviced Patient Calls received by HealthLink 811
- Number of Primary Health Care Providers Who Have Undergone Advanced Self Management Support Training
- Number of Primary Health Care Teams in Nova Scotia
- Number of Chronic Disease Self-Management Program Sessions
- Number of Primary Health Care Teams Offering Advanced Access – Same Day or Next Day Access
- Participation Rates in the Colon Cancer Prevention Program (CCPP)
- Percent of Applicable Response Time Standards Met or Exceeded
- Percent of Service Inquiries Investigated and Closed Within 20 Days
- Number of Cultural Competency Guidelines Implemented
- Breastfeeding Initiation Rate: Percentage of Infants Receiving Breast milk and/or Who Had Early Breast Contact
- Percent of Nova Scotia Population (12 yrs +) Who Report Eating at Least 5-10 Servings of Fruit/Vegetables Per Day
- Percent of Food Insecure Households
- Smoking indicators
  - Percentage of Young Adults Aged 20 to 24 Who Smoke
  - Percentage of Population Aged 25 and Over Who Smoke
- Injury-related Mortality Rate (rate per 100,000)
- Percent of adults (20 years of age and older) Active Enough for Health Benefits

- Percent of Junior High Girls Active Enough for Health Benefits
- Percent of Adults with a Gambling Problem
- Percent of the Nova Scotia Population Aged 15 years and Older and Currently Experiencing Harms from their Drinking
- Human Papillomavirus (HPV) Vaccine Coverage Rate for School-Based Female Population
- Financial results with an explanation of significant variances are also provided in the report.

The 2012/2013 Statement of Mandate for the Department of Health and Wellness includes the following 21 performance measures:

- Percent of Patients with Total Length of Stay from Triage to Emergency Department Departure within Emergency Care Standards indicators
    - Percent of Canadian Emergency Department Triage and Acuity Scale (CTAS) 1- 3 Patients with Total Length of Stay from Triage to Emergency Department Departure Being Within 8 Hours
    - Percent of CTAS 4 – 5 Patients with Total Length of Stay from Triage to Emergency Department Departure Being Within 4 Hours
- Percent of CTAS 4 – 5 Patients Being Seen in Emergency Departments
- Number of hours that Collaborative Emergency Centres (CECs) are closed
- Percent change in number of long waiting (1+ years) patients waiting for surgery
- Percent of Adult and Child/Adolescent Mental Health Clients Seen Within the Provincial Wait Time Standard
- Number of new health care providers implementing EMR in their daily practice
- Electronic Health Record (EHR) Initiative – Number of Clinical Users of SHARE (Secure Health Access Record)
- Percent of Nova Scotia Population (12 yrs +) Who Report Eating at Least 5-10 Servings of Fruit/Vegetables Per Day
- Percent of Food Insecure Households
- Percent of Junior High Girls Active Enough for Health Benefits
- Prevalence of 18 years and older who are at risk for or have gambling problems and seek treatment services
- Breastfeeding Initiation Rate: Percentage of Infants Receiving Breast milk and/or Who Had Early Breast Contact
- Percent of women who exclusively breastfeed for at least 6 months
- Prevalence of adolescents aged 13-18 years who engage in organized forms of gambling
- Percent of the Nova Scotia Population Aged 15 years and Older and Currently Experiencing Harms from their Drinking
- Smoking indicators
    - Percentage of Young Adults Aged 15 to 19 Who Smoke
    - Percentage of Young Adults Aged 20 to 24 Who Smoke
    - Percentage of Population Aged 25 and Over Who Smoke
- Retention Rate of New Nurse Graduates
- Projected budget for upcoming year

In addition to the system wide indicators listed above, the Department of Health and Wellness also provides access to the Annual Accountability Report on Emergency Departments which provides statistics and measures specific Emergency Departments in Nova Scotia.

The reporting requirements of the district health authorities in Nova Scotia are mandated in the Health Authorities Act. Each health district publishes an annual report which provides measures specific to each district.

Reporting: Department of Community Services

The Department of Community Services publishes performance measures in its annual Accountability Report and Statement of Mandate. All 17 performance measures listed in the 2011/2012 Accountability Report were the same as the performance measures included in the 2012/2013 Statement of Mandate. For each performance indicator, a description is provided for what the indicator measures, what the current value of the measure is, and future targets. The 17 performance measures include:

- Number and Percent of Nova Scotians Living in Poverty based on the after-tax low-income cut-off (After-Tax LICO)
- Number and Percentage of Children Living in Poverty based on the after-tax low-income cut-off (After-Tax LICO)
- Average Monthly Beneficiaries as a Percentage of the Population based on the average number of people on the department"s income assistance caseload each fiscal year as a percentage of Nova Scotia"s population
- Percentage of Income Assistance Recipients with Wage Income
- Youth Assisted to Enhance Employability
- The number and percentage of households unable to access acceptable housing
- Co-operative housing ranking based on the % of co-operative organizations "in difficulty"
- Households Assisted with Health and Safety Repairs
- Public Housing Vacancy Rate
- Number of Children in Care Placed for Adoption
- Number of Child Care Spaces
- Child Care Subsidies based on the percentage of subsidized spaces
- Participation in the Direct Family Support for Children program
- Number of Clients Served by Adult Service Centres
- Number of Services for Persons with Disabilities (SPD) Licensed Facilities with Escalated Non-Compliance
- Licensing Turnaround Time based on the % of the department"s licenses that meet the 10 day service standard
- Financial results with an explanation of significant variances are also provided in the report.

In addition to the measures listed above, the department also provides access to the Nova Scotia Housing Development Corporation Annual Accountability Report and Business Plan on its website. The 2011/2012 Accountability Report and 2012/2013 Business Plan for the Housing Development Corporation include performance measures specific to the organization.

United Kingdom - NHS

NHS Outcomes Framework 2011/12

1

Overarching indicators

1a Mortality from causes considered amenable to healthcare
(The NHS Commissioning Board would be expected to focus on improving mortality in all the components of amenable mortality as well as the overall rate)
1b Life expectancy at 75

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease*
1.2 Under 75 mortality rate from respiratory disease*
1.3 Under 75 mortality rate from liver disease*
1.4 Cancer survival
- i One- and ii five-year survival from colorectal cancer
- iii One- and iv five-year survival from breast cancer
- v One- and vi five-year survival from lung cancer

Reducing premature death in people with serious mental illness
1.5 *Under 75 mortality rate in people with serious mental illness**

Reducing deaths in babies and young children
1.6.i Infant mortality*
1.6.ii Perinatal mortality (including stillbirths)

2 Enhancing quality of life for people with long term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions (EQ-5D)**

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition***

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions

Reducing time spent in hospital by people with long-term conditions
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers (EQ-5D)**

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 28 days of discharge from hospital***

Improvement areas

Improving outcomes from planned procedures
3.1 Patient-reported outcomes measures (PROMs) for elective procedures

Preventing lower respiratory tract infections (LRTIs) in children from becoming serious
3.2 Emergency admissions for children with LRTIs

Improving recovery from injuries and trauma
3.3 *An indicator needs to be developed*

Improving recovery from stroke
3.4 *An indicator needs to be developed.*

Improving recovery from fragility fractures
3.5 The proportion of patients recovering to their previous levels of mobility/ walking ability at i 30 days and ii 120 days***

Helping older people to recover their independence after illness or injury
3.6 The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services***

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
4b Patient experience of hospital care

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to inpatients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 *An indicator needs to be developed based on the survey of bereaved carers*

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
4.8 *An indicator needs to be developed.*

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators

5a Patient safety incident reporting
5b Severity of harm
5c Number of similar incidents

Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare-associated infection (HCAI)
- i MRSA
- ii *C difficile*

5.3 Incidence of newly acquired category 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to failure to monitor'

One framework
Five domains
Ten overarching indicators
Thirty-one improvement areas
Fifty-one indicators in total

The NHS Outcomes Framework 2011/12 at a glance

*Shared responsibility with Public Health England

**EQ-5D™ is a trademark of the EuroQol Group. Further details can be found at www.euroqol.org

***Indicator also included in the Adult Social Care Outcomes Framework

Indicators in italics are placeholders, pending development or identification of a suitable indicator

NHS Outcomes Framework 2013/14

1 Preventing people from dying prematurely

Overarching indicators

1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
- i Adults ii *Children and young people*

1b Life expectancy at 75
- i Males ii Females

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease* (PHOF 4.4)
1.2 Under 75 mortality rate from respiratory disease* (PHOF 4.1)
1.3 Under 75 mortality rate from liver disease* (PHOF 4.6)
1.4 Under 75 mortality rate from cancer* (PHOF 4.5)
- i *One- and* ii *Five-year survival from all cancers*
- iii *One- and* iv *Five-year survival from breast, lung and colorectal cancer*

Reducing premature death in people with serious mental illness
1.5 Excess under 75 mortality rate in adults with serious mental illness* (PHOF 4.9)

Reducing deaths in babies and young children
1.6 i Infant mortality* (PHOF 4.1)
- ii Neonatal mortality and stillbirths
- iii *Five year survival from all cancers in children*

Reducing premature death in people with a learning disability
1.7 *Excess under 60 mortality rate in adults with a learning disability*

2 Enhancing quality of life for people with long-term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions** (ASCOF 1A)

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition**

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions** (ASCOF 1E, PHOF 1.8)

Reducing time spent in hospital by people with long-term conditions
2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
- ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers** (ASCOF 1D)

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness**** (ASCOF 1F & PHOF 1.5)

Enhancing quality of life for people with dementia
2.6 i Estimated diagnosis rate for people with dementia* (PHOF 4.16)
- ii *A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life**** (ASCOF 2F)

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital* (PHOF 4.11)

Improvement areas

Improving outcomes from planned treatments
3.1 Total health gain as assessed by patients for elective procedures
- i Hip replacement ii Knee replacement iii Groin hernia iv Varicose veins
- v *Psychological therapies*

Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
3.3 Proportion of people who recover from major trauma

Improving recovery from stroke
3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months

Improving recovery from fragility fractures
3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation service*** (ASCOF 2B)
- ii Proportion offered rehabilitation following discharge from acute or community hospital

NHS Outcomes Framework 2013/14

at a glance

Alignment across the Health and Social Care System

* Indicator shared with Public Health Outcomes Framework (PHOF)
** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)
*** Indicator shared with Adult Social Care Outcomes Framework
**** Indicator complementary with Adult Social Care Outcomes Framework and Public Health Outcomes Framework

Indicators in Italics are placeholders, pending development or identification

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
- i GP services
- ii GP Out of Hours services
- iii NHS Dental Services

4b Patient experience of hospital care
4c *Friends and family test*

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii NHS dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 Bereaved carers' views on the quality of care in the last 3 months of life

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
4.8 An indicator is under development

Improving people's experience of integrated care
4.9 An indicator is under development *** (ASCOF 3E)

5 Treating and caring for people in a safe environment and protect them from avoidable harm

Overarching indicators

5a Patient safety incidents reported
5b Safety incidents involving severe harm or death
5c *Hospital deaths attributable to problems in care*

Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare associated infection (HCAI)
- i MRSA
- ii C. difficile

5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

Appendix D: Excerpt from Business Process Design Report

Included in the appendix below are excerpted sections from the 2011 Business Process Design Report completed by MNP for the Department of Health and Social Services. These excerpted sections provide detail on accountability concepts that MNP recommends be considered as elements of the accountability framework proposed in Section 8.0.

Key Roles and Responsibilities

Key roles and responsibilities for system participants need to be clearly defined, communicated and understood to ensure a viable and sustainable system. The table below outlines the key roles and responsibilities of the GNWT, Department of HSS, a Governance Board and HSSAs. Mechanisms used to define roles and responsibilities are further defined in subsequent tables: Accountability Mechanisms; and Governance Mechanisms.

Key Roles and Responsibilities

Role	Responsibility	Mechanisms
Government of NWT		
Define the boundaries of authority given to DHSS and HSSAs		- Legislation: acts and regulation
Approve budget and provide sufficient funds		- Finance Board - Main Estimates
Establish legislative priorities for NWT		- Cabinet and Standing Committee
Deliver some back office consolidation functions through departments		- Service agreements
Department of Health and Social Services		
Provide System Direction	Ensure NWT adheres to principles of accessibility, universality, portability, comprehensiveness and public administration	- Canada Health Act
	Understand, measure and report the health status of NWT residents	- Health Status Report
	Set Health and Social System direction and territorial priorities for health and social services	- System Strategic Plan
	Recommend budget to Financial Management Board	- Funding Model
	Establish appropriate funding model and ensure fiscal accountability	- Funding Model
	Establish, maintain and communicate Health and Social Services regulations, acts, standards, policies and directives	- Program Standards - Department Policies - Ministerial Directives

Support and Compliance	Define the programs, services, infrastructure, access, quality and relevance of health and social services	– DHSS Business Plan and Action Plan – ISDM
	Provide services regarding vital statistics, registration of health care, insured services, extended health benefits, and non-insured health benefits.	– Health Services Administration
	Establish expectations of HSSAs • Define limits and boundaries to authority and responsibility assigned to the HSSAs • Define service delivery requirements – insured services and benefits • Define performance requirements, indicators and reporting requirements	– Accountability Agreement
	Ensure compliance with authority and associated responsibilities through reporting process	– Annual DHSS performance and variance reports – Audited DHSS financial statements
System Collaboration	Maintain and build intergovernmental linkages	– Committees – Task Forces
	Communicate to and engage with system stakeholders	– Community level forums – Community Health Services Satisfaction Reports
	Support and collaborate with the NWT HSSA	– JSMC, JLC
	Redirect issues or complaints	– Patient concerns resolution process
Health and Social Service Authority Board		
Accountability	Promote ethical and responsible decision making by establishing a code of conduct and defining organizational values	– Board Charter and by-laws
	Safeguard integrity in financial reporting by having the capacity to understand financial information, hiring reputable external auditors and establishing an audit committee function	– Financial Administrations Act – Governance Terms of Reference and Policies – Audited financial reports
	Ensure timely and balanced disclosures by having a relevant communication structure as defined by any regulatory requirements with a balance between good news and bad	– Board Charter – Quarterly and annual performance and variance reports
	Understand and respect the rights and needs of stakeholders by establishing communication policies, publishing annual reports and other communications to stakeholders	– Community Level Forums – Quarterly and annual performance and

		variance reports
Stewardship	Establish responsibilities of board and management by establishing governance policies, defining CEO, Chair and board member job descriptions, and defining committee structures and mandates	– Board Charter – Position descriptions – Terms of Reference – Policies and By-laws
	Ensure CEO competence, performance and succession	– Position Description – Policies and By-laws
	Understand risk and risk management by identifying the risks, understanding potential risks, and understanding management"s risk identification and mitigation plans	– Risk Management Plan – Terms of Reference
	Relationship management with CEO, Minister and Stakeholders	– JLC and JSMC – Community level forums
Performance and Effectiveness	Ensure an effective and transparent appointment process that ensures: • Regional and cultural representation • Health and social service sector experts • Functional experts (strategy, operations, finance, communication, HR)	– Board Charter – Policies and By-laws
	Add value through an effective board chair who ensures positive dynamics at the board table	– Position Description – Policies and By-laws
	Add value by measuring individual board members, board as a whole and board chair	– Position Description – Policies and By-laws
	Add value by ensuring a positive board and organization culture • Board orientation, development and training • Board assessment • Recommendation to Government regarding succession of board members	– Board Charter – Terms of Reference – Policies and By-laws
Health and Social Service Authority		
Overall direction and planning	Gather public and other stakeholder input	– Community level forums
	Assess health status and health needs of population	– Community level forums – Health status monitoring
	Define, implement and review organizational policies and by-laws	– HSSA Policies and By-laws
	Comply with acts, regulations, territorial policies and ministerial directives	– DHSS Strategic Plan
Relationship management	Between Board and Minister of Health and Social Services	– Joint Leadership Committee
	Between Department (DM, ADM and department directors) and HSSA (CEO and management)	– JSMC, committees, task forces

	With regions, communities and NWT residents Community relations function Approach will be different within each region or even community depending on context	– Community level forums o Print and Radio, etc – Patient concerns resolution process
	With other stakeholders (professional associations, NGOs, special interest groups)	– Working Groups – Committees
Service delivery integration	ISDM implementation through Regional Delivery Centres	– HSSA Policies – HSSA Business Plan / Action Plans – Task Force
	Medical Officer of Health, hospital privileges, medical staff bylaws	– Policies and By-laws – Committee
	Define, implement and review clinical service delivery standards	– Policies and By-laws – Task Force
	Contractual arrangements with NGOs for service delivery	– Service agreements
	Medical travel coordination and administration	– HSSA Policies – Committee
Fiscal management	Establish fiscal policies and internal controls	– Financial policies and by-laws
	Budget, allocate and report financial resources for service delivery	– Budgets/projections
	Review fiscal performance and variance reports quarterly and take required action	– Quarterly and annual HSSA performance and variance reports – Audited annual HSSA financial statements
Risk management and Quality Assurance	Define, implement and support a risk management process	– Identify, mitigate, manage and report risk
	Address concerns from NWT residents or through Department	– Patient concern resolution process
Performance management	Monitor, evaluate and report delivery of quality health and social services	– Quarterly and annual performance and variance reports o Performance indicators o Measurement tools
	Respond to compliance and performance concerns	– Quarterly and annual performance and variance reports

The previous table provides a detailed summary of the roles, responsibilities and mechanisms for accountability. The table below further defines the authority relative to each system participant and provides a summary of responsibility and methods for communication.

Summary of Roles, Authority, Responsibilities and the Methods for Communication.

Role	*Authority*	*Responsibility*	*Methods*
GNWT Provide overall direction & support	Within limits, decides on and delivers: • Policies, strategic priorities and goals Within limits, delegates authority to DHSS • Health and social services	• Define policies, strategic priorities and goals • Define delegated authority • Provide sufficient resources to DHSS to fulfill authority and responsibilities • Deliver some back office consolidation	• Acts and Regulations
DHSS Provide direction & implementation support	Within limits, decides and delivers: • Strategic priorities and service delivery standards Within limits, decides and delegates responsibility to deliver: • Services and programs Within limits, delegates authority for: • Back office consolidation • Clinical collaboration	• Define strategic priorities for health system • Define core services and programs standards, performance indicators, and ensure compliance • Define delegated authority and responsibilities • Provide sufficient resources to divisions of DHSS and NWT HSSA to fulfill delegated authority and responsibilities • Coordinate efforts with other GNWT departments	• Special Ministerial Task Forces • Strategic Plan • Accountability Agreement with NWT HSSA • Joint Senior Management Committee • Joint Leadership Committee
HSSA Implementation	Within limits, decides and delivers: • Services and programs • Clinical standards Within limits, decides and delegates responsibility to deliver: • Back office consolidation • Clinical collaboration	• Define vision, mission and values for HSSA • Define decisions made • Define and deliver system integration • Deliver defined tertiary services to residents of territory • Deliver assigned secondary services to residents of region and territory • Deliver assigned primary services to residents of region • Deliver assigned clinical coordination, back office consolidation, or clinical support consolidation • Gather input and feedback from communities	• Board committees • Strategic and Business plans with financial forecasts/budgets • Accountability/Contribution/ Service agreements with GNWT and NGOs as required • Business and action plans with financial forecasts/budgets • Hospital accreditation process • Community level forums

Accountability Mechanisms

Accountability mechanisms outlined in the table below will help to ensure successful implementation of the recommended system structure. To more clearly communicate accountability to HSSAs we are recommending the development of an annual accountability agreement. This is discussed in more detail in a subsequent section.

Accountability Mechanisms

Role	Mechanism	Description
Communicate Roles, Responsibilities and Expectations		
Department of H&SS	Ministerial Directives	Provides direction to DHSS and HSSAs regarding performance expectations on special events or emerging issues. Should a special event or an emerging issue become a permanent situation then policies or standards will need to be developed or updated
	Program Standards	Provides direction to DHSS and HSSAs regarding program performance expectations on permanent programs
	Clinical Standards	Provides direction and guidance to DHSS, HSSAs, and clinicians regarding clinical standards of care and expectations
	Department Policies	Provides direction to DHSS and HSSAs regarding general performance expectations on a specific situation
	System Strategic Plan	Based on Budget Address, Legislation and Main Estimates – outlines current state, vision, mission, values and system strategic priorities
	System Business Plan	Based on System Strategic Plan – outlines department structure, services, communication strategy, operational requirements and associated departmental projections
	System Action Plan	Based on System Business Plans - details projects and required actions with associated outcomes, responsibilities, timelines and required resources
	Accountability Agreement with HSSA	An agreement between the DHSS and the HSSA outlining authority, roles, responsibilities, performance expectations, accountability and funding
	Contribution Agreements	Provides direction to NGOs and other governments regarding contracted service delivery, roles, responsibilities, performance expectations, accountability and funding
H&SS Authority	HSSA Business Plan with budgets or projections	Provides direction to HSSA regarding structure, services, communications, operations, resource requirements (people, financial and infrastructure) and associated performance indicators
	Contribution Agreements	Provides direction to NGOs and other governments regarding contracted service delivery, roles, responsibilities, performance expectations, accountability and funding
Communicate Performance and Variance to Expectations		
Government	Public Accounts	Consolidated financial statements for all departments within

Role	Mechanism	Description
of NWT		the GNWT
Department of H&SS	NWT Health Status Reports	Published every five years, it provides a measure of NWT population"s health and well being
	Annual Report	Published annually to provide a snapshot of the health and social services system performance against goals including summary of expenditures
	Performance Measures Report	An annual report on progress against the defined system performance measures (can be combined with the annual report)
	Patient/Client engagement summary	Report most recently published in 2009 based on satisfaction questionnaires distributed during 2008
	Patient Concern Resolution Process	Defined process in collaboration with the HSSA to examine and address patient concerns
H&SS Authority	Quarterly and Annual HSSA Performance and Variance Reports	A report of HSSA performance against expectations detailed in the accountability agreement
	Annual Audited HSSA Financial Statements	Provides a measure of system financial performance and how it compares to expectations detailed in the annual accountability agreement

Challenges in Current Framework (2011)

In our opinion, the current health system framework does not ensure sufficient accountability and has inadequate controls. This is due to a number of factors:

- The DHSS has not specifically defined or communicated consistent program standards and associated performance indicators to measure outputs or outcomes of funded programs and services. This is required to communicate consistent system and program performance expectations, measures and indicators within an Accountability Agreement. This will ensure HSSA reports provide the data and information required to communicate HSSA performance and as a result system performance.
- The DHSS does not have adequate capacity to provide feedback to, or follow up with, eight HSSAs regarding the required content or timeliness of HSSA annual reports or financial reports. This is required to understand HSSA and system performance and ensure compliance.
- The HSSAs have limited capacity (human resources and information systems) to measure and report on program and service delivery performance indicators. This is required to understand system performance.

This section provides direction to address challenges that have been identified in the framework.

Service Delivery Expectations

Service delivery expectations need to be developed and documented for the system. In particular, access points should be defined for all primary, secondary and territorial services along with the required infrastructure and resources. This is required to support a funding model and define service and program delivery expectations for each HSSA.

Program Standards

Program Standards have not been consistently defined for all HSS programs. In addition, some that have been defined are not always relevant for NWT delivery. Program standards are required to communicate performance expectations and associated performance indicators to HSSAs.

System and Program Performance Indicators

To understand HSSA and system performance, consistent system and program performance indicators must be developed. Data collection tools and resources will also be required to ensure indicators are measured and data is collected, analyzed and findings are presented in required reports. This will increase the system"s ability to ensure compliance and control, quality assurance, and risk management.

Recommended Accountability Framework (2011)

An accountability framework provides a visual representation of health and social service system management roles, responsibilities, performance expectations, and reporting measures. A recommended framework was developed during the Business Process review completed in 2011 and is presented below. This accountability framework served as the starting point for development of the framework presented in Section 8.0.

	Set Direction Provide overall system guidance and funding and define limits to authority	Manage Performance Define, communicate, and measure performance on roles, responsibilities, and expectations	Report Communicate performance on outputs and outcomes
GNWT	• Develop and maintain Legislation • Set System Vision, Values, strategic objectives and priorities • Define integrated service delivery model • Provide appropriate system funding	• Provide clear communication of program standards, department policies, and performance expectations • Provide consistent measures and indicators for system performance • Provide a funding model aligned to service delivery expectations • Measure citizen health status	• Compliance to legislation and standards • Current state and changes to citizen health outcomes and health status • Fiscally responsible spending • Meet national reporting requirements
HSSA	• Set HSSA vision, values, strategic objectives and priorities • Define and communicate Board Charter and code of conduct • Define and communicate Board by-laws • Define and communicate Board Terms of Reference	• Develop and implement consistent operational policies • Provide appropriate access to programs and services • Ensure ongoing performance measurement • Ensure program evaluation • Ensure Hospital Accreditations	• Program and service performance on outputs and outcomes • Current state and changes to infrastructure and resources • Risk management activities • Audited financial statements
Stakeholders	• Collaboration between GNWT and HSSA (JLC) • Coordination and cooperation with Health Canada • Communication with stakeholders	• Collaboration between GNWT DHSS and HSSA (JSMC) • Coordination with other GNWT departments, FNIHB, self government • Cooperation with communities, professional associations, health organizations, and other jurisdictions • Communication with residents and other stakeholders	• Alignment with Health Canada and regulatory bodies • Collaborative, coordinated, cooperative and informed system planning and performance • NWT citizen accessing the right service provided in the right place at the right time

Accountability Agreement

As identified in the section on accountability instruments, to more clearly communicate accountability to HSSAs we are recommending the development of an Accountability Agreement. The purpose of this agreement is to ensure mutual understanding of roles, responsibilities, associated performance expectations, required resources, and reporting requirements to ensure accountability. To reinforce the accountability framework proposed, the current Contribution Agreement will need to be modified. The outline presented in the table below is an initial recommendation that should be reviewed and modified by the DHSS as required.

Accountability Agreement

Agreement Section/Schedule	Description	Current State
Sections 1 through 12		
Section 1.0 Purpose of Agreement	Refers to relevant Legislation and Acts (compliance). Defines overall Mission: To promote, protect and provide for the health and wellbeing of the people of the NWT. Wellness, Accessibility and Sustainability. Defines purpose of agreement: To communicate roles, responsibilities, performance expectations, reporting requirements and associated funding allocations to the HSSAs.	Does not exist currently
Section 2.0 Definitions	Provide definitions for key terms used in the Agreement.	Currently exists as Section 1.0 Will need to be updated with additional terms used within new Schedules
Section 3.0 Term	Timeline of agreement. For example: April 1, 2011 to March 31, 2012.	Currently exists as Section 2.0
Section 4.0 Financial Contribution and Related Provisions	Define the total amount to be paid and payment installment amounts and dates. Will refer to relevant schedules: • Schedule 6 – Financial Administration • Schedule 7 – Compliance • Schedule 8 – Budget	Currently exists as Section 3.0 and Schedule 2 Will need to be updated to refer to appropriate Schedules
Section 5.0 Accountability	Defines Accountability and refers to relevant schedules: • Schedule 2 – System Integration and Planning • Schedule 3 – Performance Requirements • Schedule 4 – Special Projects • Schedule 5 – eHealth • Schedule 7 – Compliance	Replaces current Section 4.0 on Reporting and Evaluation Will need to be developed

Agreement Section/Schedule	Description	Current State
Section 6.0 Audits and Inspections	Defines expectations and process for GNWT audit or inspection.	Currently exists as Section 5.0 Will need to determine if information is still valid.
Section 7.0 Confidentiality	Defines expectations regarding confidentiality. Refers to relevant Legislation.	Currently exists as Section 6.0
Section 8.0 Liability and Indemnity	Defines responsibility of GNWT and HSSA regarding liability and indemnity.	Currently exists as Section 7.0
Section 9.0 Insurance	Defines expectations regarding insurance. Refers to Schedule 9.	Currently exists as Section 8.0
Section 10.0 Termination	Defines rights of GNWT regarding termination.	Currently exists as Section 9.0
Section 11.0 Dispute Resolution	Defines protocol for dispute resolution between GNWT and HSSA.	Currently exists as Section 10.0
Section 12.0 General	Defines protocol for amendments, notifications, and other general statements. Contact information for both GNWT and HSSA.	Currently exists as Section 11.0
Schedules 1 through 9		
Schedule 1 General	Provides a description of the schedules' purpose, current state and future development. This section will also identify the Schedules that are currently under development and therefore require updating on an annual basis.	Does not currently exist
Schedule 2 System Integration and Planning	Outlines the limits of authority (scope of decision making), roles and responsibilities, and accountability. Provides detail regarding the expectations and required protocol for community engagement, system planning, and system integration.	Does not currently exist
Schedule 3 Performance Requirements	Provides detail regarding system performance expectations for clearly defined core services that align to the ISDM. This section will also identify any program standards that need to be followed along with performance indicators, associated measures and variance resolution.	Does not currently exist
Schedule 4 Special Projects	Defines any special projects or programs that are not core-funded and identify associated agreements and funding allocations.	Does not currently exist

Agreement Section/Schedule	Description	Current State
Schedule 5 eHealth	Identifies performance requirements for the collection, storage and use of data and information for health system management and defines expectations regarding eHealth.	Does not currently exist
Schedule 6 Financial Policies and Protocol	Identifies performance requirements for effective financial management and administration. This would include reference to applicable Legislation, policies, and protocol. Please refer to Table 6 Financial Instruments and Table 7 Financial Protocols for more information	Some information can currently be found in Section 3.0 Will need to be supplemented by additional information on financial policies and protocol
Schedule 7 Compliance	Outlines compliance protocols. For example reporting format, content and timing requirements, rewards for successful performance, and consequences or required interventions for poor performance. This section should include a summary table of all required reporting and timelines to monitor compliance.	Currently exists as Schedule 3. Will need to be supplemented by detail regarding reporting format and content.
Schedule 8 Budget	Defines the budget. Ensure the budget is aligned with performance expectations of service delivery and administration responsibilities as defined in legislation, accountability agreement, policies and program standards.	Currently exists as Schedule 1 and Schedule 1.1. Will need to be revised categories in funding model
Schedule 9 Insurance Requirements	Detail regarding HSSA and GNWT responsibilities regarding insurance.	Currently exists as Schedule 4.

Appendix E: Selected Indicators

Quadrant	Dimension	Indicator #	Indicator (s)	Frequency of Reporting	Recommended Data Source	Notes
Inputs & Characteristics						
	Leadership and Governance	1	The quarterly proportion of actual HSSA expense under or over projected expenses (variance reporting).	Quarterly - internal Annually - external	DHSS (Finance)	
		2	The proportion of HSSAs with published, current operating (health and social service) plan and annual report	Annually	DHSS	An annual manual count
	Health and Social Service System Resources	3	The rate of critical incidents per 1,000 employee days worked	Annually	DHSS	
		4	Vacancy rate per staffing category (Physician, Nursing, Allied Health, Social Worker)	Annually	DHSS (Human Resources)	Currently reporting
	Efficient Allocation of Resources	5	Average wait times by type of surgery (time of booking to surgery)	Annually	Stanton HSSA	Dr. Corkal advises that this is manually kept currently. Requires template creation. When reporting on this indicator, consideration will need to be given to comparing results to national benchmarks.
		6	Average wait time for offer of placement in a long term care facility	Annually	DHSS (TAC)	Information should be readily available. May require template creation
	Adjustment to Population Health Needs					
	Health and Social Service System Innovation & Learning Capacity	7	Rate of adoption of newly established clinical standards of care	Annually	Committee to develop	This indicator on the rate of adoption of newly established clinical standards of care provides information that is important from a compliance perspective, and also in the context of the receipt of $500,000 in new funding to support the related work of a committee on developing these standards. Note that this committee could play a role in further specifying the reporting on this indicator.
Outputs						
	Access to Comprehensive Integrated Health and Social Services	8	Utilization rate of tele-health technology for patient care activities	Annually	DHSS	Tele-health technology represents a strategic priority for the GNWT, and there have been substantial investments put toward its use.
		9	Number (%) of children receiving child welfare care in their home community, by age group and demographic (Aboriginal)	Annually	DHSS	Will require template creation
		10	The number of patients and the number of escorts using the medical travel program per fiscal year	Annually	DHSS	
	Health Protection, Health Promotion, and Disease Prevention	11	Proportion of the population receiving full immunization coverage by the age of two years	Annually	Population Health	This is an important measure for the health and social services system, however currently challenges will be faced collecting this data. Felt to be important enough to remain.
		12	Incidence rate of sexually transmitted infection in NWT	Annually	Population Health, NWT Bureau of Statistics and Public Health Agency of Canada	
	Quality, Safety and Appropriateness of Health and Social Service Services	13	Average number of critical incidents reported: a) per 1,000 inpatient bed days, and b) per 1,000 outpatient visits	Annually	DHSS	Will require template creation. There is a patient safety framework under development by the department and that has linkages to this indicator.
		14	Average number of placements per year per child: Aboriginal and non-Aboriginal	Annually	DHSS	Will require template creation
	Patient Experience with Health and Social Service Services	15	Percentage of NWT residents satisfied or very satisfied with the health and/or social service care received in NWT in the past year (e.g. Hospital year 1, LTC year 2, Primary Health year 3)	Annually	DHSS Survey	Would report different sites each year (eg. Hospital, LTC, Primary Health, Outpatient). As noted earlier, there is a need to report on the quality of experience for those utilizing mental health and substance use services. Satisfaction of experiences with medical travel is another category, although this might ultimately become a separate questionnaire that is administered by phone, as contact information is available. This indicator should draw on the work of the Institute for Citizen Centered Service (http://www.iccs-isac.org/cmt/about-the-cmt/) including the use of scaled questions on the importance of, and satisfaction with, aspects of experience such as the ease of access (location, physical access, hours of service, use of alternative means including online, etc), timely provision of the service, being treated with respect and empathy, protection of privacy, receiving the service that was needed, and access to needed, understandable information. Currently, this type of surveying occurs within facilities and is carried out by administrative staff, on a given month in a calendar year. There are inconsistencies in the administration of these surveys across the regions and
	Efficiency and Effectiveness of Health and Social Services	16	Percentage of no shows (cancellations) that could not be rescheduled: general, specialist, and by HSSA	Annually	DHSS	This indicator provides for an understanding of "lost access" for other participants in the health and social services system. The collection of related data is now more consistent and covers a range of health and social services.
Outcomes						
	Improve Health Status of NWT Citizens	17	Incidence rate of cancer by type	Annually	DHSS	Report on types on rotating basis (e.g. Breast year 1, colorectal year 2, lung year 3 then repeat)
		18	Incidence rate of diabetes	Annually	DHSS	
		19	Self-reported health status of NWT residents	Annually	Stats Canada Survey	Annually may show little variation, but very relevant to the public
	Improve Health and Social Service System Responsiveness	Repeat of # 5	Average wait times by type of surgery (time of booking to surgery)	Annually	Stanton HSSA	Dr. Corkal advises that this is manually kept currently. Requires template creation. When reporting on this indicator, consideration will need to be given to comparing results to national benchmarks.
		20	Average length of time between specialist referral and specialist appointment	Annually	DHSS	It will be important in defining this indicator to consider the points in time that are being captured. For example, the time of physician referral to the specialist confirmation of an appointment, and then from the time of specialist confirmation to the actual appointment. Note that the data associated with this indicator pertains to specialist appointments that take place within the Northwest Territories (i.e., referrals to specialists in jurisdictions such as Alberta are excluded).
	Improve Value for Money					
Social Determinants of Health						
	Genetic Endowment	21	The proportion of children who are developing well at school entry	Annually	Education Culture and Employment	Wil need to work closely with ECE to develop tracking mechanism
	Social Position					
	Life Conditions	22	Percentage of NWT population who smoke	Annually	Cdn Community Health Survey	
		23	Percentage of NWT population with reported substance abuse issues	Annually	Stats Canada & DHSS	Annually binge drinking reported via Stats Canada & every 3 years detailed DHSS survey
		24	Proportion of all children placed in homes where at least one of the caregivers is from the same culture as the child	Annually	DHSS	Requires determination of whether Social Services can track.
		25	Percentage of NWT population who are obese	Annually	Cdn Community Health Survey	
	Physical Environment					

Appendix F: Non - Selected Indicators

Quadrant	Dimension	Indicator #	Indicator (s)	Notes
Inputs & Characteristics				
	Leadership and Governance			
	Health and Social Service System Resources	**26**	Number of WCSS claims	Not identified as a priority
	Efficient Allocation of Resources	**27**	Physician utilization (#) of electronic medical records by community with EMR	There is an expectation that 100% of physicians will utilize so no need to measure
		28	Average wait time for placement in a long-term care facility	Average wait times for the offer of placement was deemed more important than this indicator, and actual placement is influenced by personal decisions regarding the location of the facility. As continuum of care strategy evolves may want to reconsider including this indicator
	Adjustment to Population Health Needs			
	Health and Social Service System Innovation & Learning Capacity	**29**	Utilization rate of tele-health technology for learning activities	Not deemed a priority at this time
Outputs				
	Access to Comprehensive Integrated Health and Social Services	**30**	Average percentage of individuals with mental illness who are satisfied with the access to, and quality of care	Merged into indicator # 14 (satisfaction questionnaire). Although there have been difficulties in the past in terms of rate and level of response, it is important to have an indicator on the quality of experience with mental health and substance use services.
	Health Protection, Health Promotion, and Disease Prevention	**31**	Percentage of mothers with new borns who participated in a pre-natal care program (by community)	Identified as a key priority for the future
		32	Average readmission rate for mental health diagnoses	Difficult to collect reliable data
	Quality, Safety and Appropriateness of Health and Social Service Services	**33**	Average number of child placement changes per year	Indicator # 13 determined to be more suitable
		34	Incidence rate of facility (Hospital, LTC) acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) in NWT	Originally on the short list, but DHSS advised to drop. Currently being reported
		35	Average percentage of biomedical equipment replaced based on life cycle schedules	Not deemed relevant to intended audiences
		36	Proportion of children who are investigated as a result of a new allegation of abuse or neglect within one year following closure of their child welfare file	Identified as a key priority for the future
	Patient Experience with Health and Social Service Services	**37**	Percentage of NWT residents reporting unexpected harm to self or an immediate family member while receiving care	Not feasible at this time
	Efficiency and Effectiveness of Health and Social Services	**38**	Average rate (proportion) of emergency room visitation by level of urgency	Not deemed a priority
Outcomes				
	Improve Health Status of NWT Citizens			
	Improve Health and Social Service System Responsiveness	**39**	Percentage of individuals with a designated GP or NP	Turnover and locums make the reliability of this indicator questionable. Keep on the radar as most other jurisdictions in Canada have this as a key indicator
		40	Average Emergency Department wait time (Cdn ED Triage and Acuity Scale (CTAS))	Identified as a key priority for the future
	Improve Value for Money			
Social Determinants of Health				
	Genetic Endowment	**42**	Incidence rate of select genetic conditions	Not deemed relevant to intended audiences
		42	Incidence rate of FASD	Identified as a key priority for the future
	Social Position	**43**	Income disparity between highest 10% and the lowest 10%	DHSS made decision to drop this indicator. It will be accounted for by the government wide anti-poverty strategy

Appendix G: Selected Indicators: Detail

Indicator # 1	
HSSA quarterly variation of projected expenses to actual expenses	
What is being measured?	The proportion of actual HSSA expense under or over projected expense.
Why is this of interest?	HSSAs are provided with an annual budget to adminster and deliver health and social services in their respective regions, and financial variance reporting is a means to ensure accountability in the system .
What does this tell us?	The number of HSSAs whose expenses are greater or less than budgetted for particular line items. This will provide insight to the DHSS regarding aa potential need for budget adjustment, and/or that a particular HSSA requires assistance re: budget mandgement.
How are we doing?	TBD
Frequency of reporting	Internal – quarterly External - annual
Data Source	DHSS (Finance)
Notes	N/A

Indicator # 2	
Number of HSSAs with published, current operating (health and social service) plans and annual reports	
What is being measured?	The proportion of HSSAs that have a: A) Health and Social Service Plan B) Annual Report
Why is this of interest?	Annual health and social service plans and reports are a means by which a HSSA can be held accountable to those that they serve. These plans and reports provide a tangible means for a HSSA to articulate its plans and results.
What does this tell us?	Whether individual HSSAs have articulated plans for service delivery, and the degree of consistency or variation between them.
How are we doing?	TBD
Frequency of reporting	Annual
Data Source	Individual HSSAs
Notes	Will be an annual manual count

Indicator # 3	
Proportion of total critical incidents that impact the safety of health and social services staff	
What is being measured?	The rate of critical incidents per 1,000 empoloyee days worked.
Why is this of interest?	The safety of staff in the health and social services system is a priority for the DHSS. All staff members should enjoy a safe work environment and understanding trends in regard to incidents that impact staff safety in a negative manner is crucial to understanding what the circumstances are that may create these situations.
What does this tell us?	Could indicate safety issues in particular facilities, programs or staffing categories that will highlight a need for further investigation to understand the reasons and develop solutions.
How are we doing?	TBD
Frequency of reporting	Annual
Data Source	DHSS
Notes	Will be an extract from critical incident reporting

Indicator # 4	
Vacancy rate per staffing category (Physician, Nursing, Allied Health, Social Worker)	
What is being measured?	The vacancy rates for family practitioners, specialist practitioners, occupational and physiotherapits, nurses and social workers, by occupation sub-type.
Why is this of interest?	These professions are key components of the health and social services system and vacancies in these positions significantly impacts the capacity of the health and social services system.
What does this tell us?	Will provide an ability to forecast staffing shortages that will in turn allow for the development of strategies to mitigate these shortages. Will highlight where recruting efforts are most specifically needed.
How are we doing?	TBD
Frequency of reporting	Annual
Data Source	DHSS (Human Resources)
Notes	Currently reporting

Indicator # 5	
Average wait times by type of surgery (time of booking to surgery)	
What is being measured?	The average time a clients waits for NWT based surgeries from the date the surgery is booked to the actual date of the surgery.
Why is this of interest?	Providing timely and efficient access to services is a priority for the DHSS and Stanton HSSA. Waiting for surgery can be a particularly stressful time for patients and their family members and regularly tracking and reporting on the average wait time can provide useful information to health and social service system administrators that can be used to find ways to minimize these waiting periods.
What does this tell us?	Could indicate increases/decreases in demand for surgery and/or identify service gaps that require attention.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	Stanton HSSA
Notes	Dr. Corkal advises that this is manually kept currently. Requires template creation. When reporting on this indicator, consideration will need to be given to comparing results to national benchmarks.

Indicator # 6	
Average wait time for offer of placement in a long-term care facility	
What is being measured?	The average time a patient waits to receive an offer of placement in a long term care facility as measured by the time between the date a determination that an individual requires placement in a LTC faciltiy to the date they are offered placement.
Why is this of interest?	Providing timely access to services is a priority for DHSS and the HSSAs.
What does this tell us?	Could indicate increases/decreases in demand for long-term care placements and/or identify service gaps that require attention.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS Territorial Admissions Committee (TAC)
Notes	N/A

Indicator # 7	
Rate of adoption of newly established clinical standards of care	
What is being measured?	The rate at which newly established standards of care are adopted by the system as a whole. For example, if a new clincal standard is developed that is appliable in long term care facilities, this will measure the rate at which all long term care facilties adopt the new standard.
Why is this of interest?	Establishing clinical standards are an identified priority for NWTs health and social service system.
What does this tell us?	Could be an indicator of inadequate training or communication of standards.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	To be developed by committee
Notes	This indicator provides information that is important from a compliance perspective, and also in the context of the receipt of $500,000 in new funding to support the related work of a committee on developing these standards. Note that this committee could play a role in further specifying the reporting on this indicator.

Indicator # 8	
Utilization rate of tele-health technology for patient care activities	
What is being measured?	The number of telehealth sessions that were specifically for patient care activities.
Why is this of interest?	Tele-health technology presents a signficant opportunity to improve access to servcies for all residents of NWT and allows for potential cost savings to be realized by using technology to minimize other health and social service costs. Telehealth helps reduce medical and staff travel by providing remote access to clinical advice for patients and professionals.
What does this tell us?	The degree to which the technology is being used for one of its stated purposes.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	Tele-health technology represents a strategic priority for the GNWT, and there have been substantial investments put toward its use.

Indicator # 9	
Number (%) of children receiving child welfare care in their home community: by age group and demographic (Aboriginal)	
What is being measured?	By age group, the percentage of children receiving child welfare care who receive that care in their home community.
Why is this of interest?	Receiving care as close to home as possible is a priority for NWTs health and social service system. The degree to which the removal of children from their home community can be prevented is seen as an important objective.
What does this tell us?	The availability of child welfare placements in communities across NWT.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	Will require template creation

Indicator # 10	
The number of patients and the number of escorts using the medical travel program per fiscal year	
What is being measured?	The number of patients and the number of escorts using the medical travel program per fiscal year
Why is this of interest?	Medical travel represents a significant percetage of the DHSS budget every year, and monitoring its use will provide the DHSS with data and information that can help inform improvements to the medical travel program.
What does this tell us?	Will idenitfy trends regarding patients and escort travel.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	N/A

Indicator # 11	
Proportion of the population receiving: full immunization coverage by the age of two years	
What is being measured?	The proportion of the total population who have received full immunization coverage by the age of two years.
Why is this of interest?	Early childhood development is a priority for the health and social services system and immunization has been shown to be one of the most cost effective public health interventions available. Maintaining high vaccine coverage is necessary for preventing the spread of vaccine preventable diseases and outbreaks within a community.
What does this tell us?	The success of NWTs immunization program.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS (Population Health)
Notes	This is an important measure for the health and social services system, however currently challenges will be faced collecting this data. Felt to be important enough to remain.

Indicator # 12	
Incidence rate of sexually transmitted infection in NWT	
What is being measured?	The incidence of sexually transmitted infection in NWT.
Why is this of interest?	The incidence of STIs in the NWT is much higher than in the rest of Canada. STIs are spread through practicing unsafe sex, and can cause infertility, ectopic pregnancies, premature births and damage to unborn children.
What does this tell us?	STI rate can provide a proxy of the degree to which unsafe sex is being practiced.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS (Population Health), NWT Bureau of Statistics, and the Public Health Agency of Canada
Notes	N/A

Indicator # 13	
Average number of critical incidents reported: a) per inpatient patient day, b) among children in foster care, and c) per outpatient visit	
What is being measured?	The rate of critical incidents reported annually: a) Per 1,000 inpatient bed days b) Per 1,000 outpatient visits
Why is this of interest?	Critical incidents are a good indicator of safety and quality of care. Ensuring care is provided in a safe environment is critical to the overall effectiveness of the health and social services system.
What does this tell us?	If there are particular sectors of the health and social services system where an issue needs to be addressed and/or where other sectors could look to for improvement opportunities.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	Will require template creation. There is a patient safety framework under development by the department and that has linkages to this indicator.

Indicator # 14	
Average number of placements per year per child: Aboriginal and non-Aboriginal	
What is being measured?	The average number of placements an individual child has per year.
Why is this of interest?	Providing stable placement environments is a priority for the health and social services system and provides for a less disruptive experience for the child
What does this tell us?	Trends in child placement.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	Will require template creation

Indicator # 15	
Percentage of NWT residents satisfied or very satisfied with the health and/or social service care received in NWT in the past year	
What is being measured?	The percentage of NWT residents who report that they were satisfied or very satisfied with the health and/or social service care received in NWT in the past year.
Why is this of interest?	Resident satisfaction with the care they have received can provide a means for the health and social services system to improve the delivery of services.
What does this tell us?	Could identify particular geographies where care is felt to be better or worse than others, potentially identifying areas for DHSS or HSSAs to investigate.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS Survey
Notes	Would report different sites each year (e.g. Hospital, LTC, Primary Health, Outpatient). There is a need to report on the quality of experience for those utilizing mental health and substance use services. Satisfaction of experiences with medical travel is another category, although this might ultimately become a separate questionnaire that is administered by phone, as contact information is available. This indicator should draw on the work of the Institute for Citizen Centered Service (http://www.iccs-isac.org/cmt/about-the-cmt/) including the use of scaled questions on the importance of, and satisfaction with, aspects of experience such as the ease of access (location, physical access, hours of service, use of alternative means including online, etc), timely provision of the service, being treated with respect and empathy, protection of privacy, receiving the service that was needed, and access to needed, understandable information. Currently, this type of surveying occurs within facilities and is carried out by administrative staff, on a given month in a calendar year. There are inconsistencies in the administration of these surveys across the regions and health authorities. Hence, there is a need to build into future contribution agreements a requirement for such surveying.

Indicator # 16	
Percentage of no-shows (cancellations) that could not be rescheduled: general, specialist, and by HSSA	
What is being measured?	The proportion of scheduled patient appointments by HSSA for: a) Family physician or nurse practitioner; and b) Specialist physicians where the patient does not show up.
Why is this of interest?	No shows at appointments with these professionals represent a significant waste and negatively impacts health resource utilization. These appointments can result in lost appointment slots that cannot be readily filled. To maintain the sustainability of the health and social serivces system, waste in the system must be minimized.
What does this tell us?	Identifies possible areas of waste in the system.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	This indicator provides for an understanding of "lost access" for other participants in the health and social services system. The collection of related data is now more consistent and covers a range of health and social services.

Indicator # 17	
Incidence rate of cancer by type	
What is being measured?	The incidence rate of cancers by specified type.
Why is this of interest?	Cancer remains one of the most significant health challenges faced by Canadians and the incidence of cancers is projected to increase in NWT.
What does this tell us?	Monitoring incidence rates is important for cancer care planners providers and policy makers as it provides them with an indication of where serivces and programming should be focused.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	Report on types on rotating basis (e.g. Breast year 1, colorectal year 2, lung year 3 then repeat)

Indicator # 18	
Incidence rate of diabetes	
What is being measured?	The incidence rate of diabetes in NWT.
Why is this of interest?	The NWT has the second highest proportion of Aboriginal population in Canada and diabetes prevalence rates among Aboriginal populations are at least 3 times higher than the general population.
What does this tell us?	Understanding the incidence of this disease is critical for health and social system planners to inform decision making regarding service provision.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	N/A

Indicator # 19	
Self-reported health status of NWT residents	
What is being measured?	Self-reported health status of NWT residents
Why is this of interest?	Self reported health status is one of the most common measures used in public health surveys in Canada and peer countries. How people feel about their own health is seen as a good indication of the burden of disease
What does this tell us?	How the citizens of NWT assess their own health status.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	Statistics Canada Survey
Notes	N/A

Indicator # 20	
Average length of time between specialist referral and specialist appointment	
What is being measured?	The average length of time between the date a specialist referral is initiated and the date of the specialist appointment.
Why is this of interest?	Providing timely access to services is a priority for DHSS and the HSSAs.
What does this tell us?	Identifies potential areas of waste in the system and allows for standard setting and benchmark measurement.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	Note that the data associated with this indicator pertains to specialist appointments that take place within the Northwest Territories (i.e., referrals to specialists in jurisdictions such as Alberta are excluded).

Indicator # 21	
The proportion of children who are developing well at school entry	
What is being measured?	The proportion of children who are developing well at school entry
Why is this of interest?	There is an overall initiative in NWT to develop a strategic and comprehensive territory-wide plan to improve the overall education system in NWT, with specific consideration as to how to enhance and strengthen student success and early childhood development. Understanding childrens needs is critical to the development of an effective strategy.
What does this tell us?	Will provide evidence to inform allocation of funding and services in the educational system.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	Will need to work closely with ECE to develop tracking mechanism.

Indicator # 22	
Percentage of NWT population who smoke	
What is being measured?	The percentage of NWT population who self report smoking
Why is this of interest?	In Canada, it is estimated that smoking is responsible for 30% of all cancer deaths and is related to more than 85% of lung cancer cases. Lung cancer is the most preventable of all cancers, however, it remains to be the leading cause of cancer death for both men and women.
What does this tell us?	Smoking trend in the NWT.
How are we doing?	TBD
Frequency of reporting	Annual
Data Source	Canadian Community Health Survey
Notes	N/A

Indicator # 23	
Percentage of NWT population with reported substance abuse issues	
What is being measured?	The proportion of NWT population reporting drinking five or more drinks at least once per month.
Why is this of interest?	NWT has one of the highest self reported substance abuse rates in Canada. NWT youth are over 5 times as likely to particiapte in heavy frequent drinking than the national average (2009 Canadian Alcohol & Drug Use Monitoring Survey). Focusing on reducing substance abuse issues, particularly in youth, is a priority for the DHSS and HSSAs.
What does this tell us?	Substance abuse trend in the NWT.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	Statistics Canada and DHSS
Notes	Annually binge drinking reported via Stats Canada & every 3 years detailed DHSS survey.

Indicator # 24	
Proportion of all children placed in homes where at least one of the caregivers is from the same culture as the child	
What is being measured?	The proportion of all children placed in homes where at least one caregiver is from the same culture as the child
Why is this of interest?	When children must be removed from their biological families, there is always an attempt to place them as much as possible within their community: this includes extended family, indifiduals emotionally connected to the child, or a family of a similar religious or ethno-cultural background. The degree to which placement in this manner can be achieved is important to the DHSS.
What does this tell us?	The degree to which NWTs services are meeting this national best practice.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	Requires development of process to track.

Indicator # 25	
Percentage of NWT population who are obese	
What is being measured?	The percentage of NWT population who self report obesity.
Why is this of interest?	According to the World Health Organization the dramatic increase in overweight and obese Canadians constitutes and epidemic. The impact of obesitiy on non-communicable diseases such as cardiovascular disease, Type 2 diabetes, and cancer is significant, making the need for prevention and control clear.
What does this tell us?	Obesity trend in the NWT.
How are we doing?	TBD
Frequency of reporting	Annual
Data Source	Canadian Community Health Survey
Notes	N/A